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ABSTRACT

This manual is intended to help train case managers to work more effectively with persons who have mental illness and are (or have been) homeless. The approach stresses assertive outreach in the community setting to improve the client's life in the community as the best means to prevent rehospitalization. The manual's 10 units address the following topics: qualities needed in an assertive community outreach worker; the client population and the model of assertive community treatment; features of mental illness and substance use disorders; general health issues among homeless persons with severe mental illness; establishment of financial security through public entitlements; the therapeutic alliance in the client's own setting; the total treatment approach--team issues and activities; establishing community support linkages with collateral service providers; processing assertive outreach experiences; and the larger picture (creating cultural relevance, increasing one's knowledge base, and impacting public policy). A 41-item bibliography is included in an appendix. (DB)

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Creating Community Linkages: A Guide To Assertive Outreach For Homeless Persons With Severe Mental Illness

Karen Engstrom
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Project Interlink is a collaborative project with Thresholds and Travelers and Immigrants Aid.

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The authors gratefully acknowledge the work and input of numerous staff and associated parties who provided ideas and discussions for this manual. We would like to thank Ms. Debra Pavick, Ms. Peggy Flaherty, and Ms. Anne Penman for their contributions to this project.

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Creating Community Linkages: A Guide to Assertive Outreach for Homeless Persons with Severe Mental Illness

Table of Contents — Page

Unit 1: You and Your New Job Setting: Qualities Needed in an Assertive Community Outreach Worker 1

Unit 2: Setting the Stage: Introduction to the Client Population and the Model of Assertive Community Treatment 8

Unit 3: Features of the Disability: Introduction to Mental Illness and Substance Use Disorders 17

Unit 4: Physical Well-Being: Introduction to General Health Issues among Homeless Persons with Severe Mental Illness 40

Unit 5: Establishing Financial Security: Introduction to Public Entitlements 44

Unit 6: Establishing a Therapeutic Alliance: Relating to the Client in His or Her Setting 55

Unit 7: The Total Treatment Approach: Team Issues and Activities 59

Unit 8: Establishing Community Support Linkages: Working with Collateral Service Providers 65

Unit 9: Making Sense of What You See and Hear: Processing Assertive Outreach Experiences 74

Unit 10: The Larger Picture: Creating Cultural Relevance, Increasing Your Knowledge Base, and Impacting Public Policy.....82

References 86

Appendix: Annotated Bibliography on Persons who are Homeless and Have a Psychiatric Disability i

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Table of Contents

		Page
Unit 1:	You and Your New Job Setting: Qualities Needed in an Assertive Community Outreach Worker	1
Unit 2:	Setting the Stage: Introduction to the Client Population and the Model of Assertive Community Treatment	8
Unit 3:	Features of the Disability: Introduction to Mental Illness and Substance Use Disorders	17
Unit 4:	Physical Well-Being: Introduction to General Health Issues among Homeless Persons with Severe Mental Illness	40
Unit 5:	Establishing Financial Security: Introduction to Public Entitlements	44
Unit 6:	Establishing a Therapeutic Alliance: Relating to the Client in His or Her Setting	55
Unit 7:	The Total Treatment Approach: Team Issues and Activities	59
Unit 8:	Establishing Community Support Linkages: Working with Collateral Service Providers	65
Unit 9:	Making Sense of What You See and Hear: Processing Assertive Outreach Experiences	74
Unit 10:	The Larger Picture: Creating Cultural Relevance, Increasing Your Knowledge Base, and Impacting Public Policy	82
References		86
Appendix:	Annotated Bibliography on Persons who are Homeless and Have a Psychiatric Disability	i

UNIT 1

You and Your New Job Setting: Qualities Needed in an Assertive Community Outreach Worker

One of the first steps that a director of any type of agency must consider when attempting to maximize effectiveness and efficiency in the job setting is **selection of candidates.** Choosing individuals who seem "right for the job" is imperative, no matter what tasks the job position demands. A position in a social service setting utilizing an assertive outreach approach is no exception to this rule. Individuals filling positions in these agencies must display certain personal characteristics and attitudes and should meet the agencies' minimum requirements for education and experience. However, when you were interviewed for this assertive outreach worker position, your present boss was probably less interested in finding out about your previous educational and employment background than in assessing whether or not your personality would be appropriate for serving a population that is one of the most challenging and rewarding in the mental health field. Since you were hired, your boss obviously felt that you met the most important criteria.

Personal Characteristics

The following characteristics are ones that your boss recognized in you during your interview for this job and which, in all probability, contributed to your being hired: your high energy; your warmth; your enthusiasm; your hopefulness; your commitment to clients' success; your willingness to take an active rather than a passive treatment stance (i.e., to work with clients in their own settings rather than in your office); and finally, your genuine desire to work with persons who have severe mental illness. These characteristics are absolutely essential in order to do outreach with persons with mental illness who are homeless; they will stand you in good stead as you proceed with this challenging job.

There are many other personal characteristics which will become more important as you gain experience in the assertive outreach field, characteristics upon which you will find yourself drawing as your exposure to more challenging clients grows. The first of these characteristics is **flexibility.** Because persons with mental illness who are homeless have a great deal of instability in their lives, you must be able to work with this instability and, in effect, to "roll with the punches" as their lives go through a series of ups and downs. Because of this instability, you must try not to take a rigid treatment stance with clients but instead be willing to adapt to frequent changes in their lives and revise your plans with them accordingly. In

this vein, you should also remember that you are in a type of partnership with your clients and, thus, should remain receptive to their ideas regarding what they would like to achieve through their collaboration with you. Finally, your work with clients will be much more fulfilling and less frustrating if you can accept clients' inconsistencies and, following this, can tolerate a degree of uncertainty and a lack of clearcut guidelines, solutions, or resolutions in your job as an assertive outreach worker.

Empathy is a second characteristic which is central to your position as an assertive outreach worker. You must have the ability to put yourself in each client's "shoes." This entails being able to feel for each client and his or her particular predicament. It also involves putting yourself in the client's place and imagining your own feelings in that kind of situation. In other words, you must regard assertive outreach as more than merely a job. As you continue to work with this population, you should develop genuine feelings for each client and a true desire to help improve the quality of clients' lives.

Patience and **persistence** are two more qualities which will be helpful to you as you become more involved in your job. Assisting the client in spite of his or her psychiatric symptoms, hesitations, and foibles will require a great deal of tenacity. At times, you will have to maintain sheer endurance when working with clients, but it is extremely important that you persist, no matter how difficult the work becomes. In the end, it is this persistence and patience that pays off and helps clients to succeed. These individuals may have lost contact with many friends and family members due to the nature of mental illness and homelessness. Therefore, becoming one of the few stable forces in clients' lives is an important goal of assertive outreach and can be accomplished mainly by being patient and persisting with clients through their most difficult periods.

Creativity is a fifth characteristic that is beneficial when working with persons with mental illness who are homeless. In an assertive outreach setting, creativity consists of being able to approach each client's situation from a number of different and unique perspectives. In other words, one cannot be afraid to try new things with clients. It is important to keep in mind that no two clients are alike; what works for one individual may not necessarily work for another. You must be able to generate a number of different alternatives to each barrier facing each client, without simply reaching for the same answers every time. Also, you should feel free to try approaching situations with solutions that may appear a bit "far-out." It is more important to make something work for a client than to worry about the route you had to take to get there.

Being **broad-sighted** is another essential ingredient for effective assertive outreach. You must have the ability to attend

to both micro and macro details in clients' lives. This means paying attention not only to occurrences in clients' immediate surroundings but also to the larger, community and national issues which may be indirectly affecting the client. This attempt to look beyond the immediate issues facing clients means intervening in their lives at more than one level and, thus, should include efforts directed at bettering the policies that affect clients. Being broad sighted in your work with clients will help them reap the maximum benefits from your assistance.

A final personal characteristic that is especially important in your career as an assertive outreach worker is the ability to maintain an **orientation toward growth**, not only for yourself but also for your clients. Being open to and desiring self-exploration and self-expansion can help to promote this same desire in your clients. As you work with clients, you must actively attempt to promote self-determination for them, so that they can move toward growth and independence, instead of becoming increasingly more dependent on you. You will find it easy to regard your experience as an assertive outreach worker as a chance to learn more about yourself as you help others.

Attitudes

There are also many helpful attitudes that accompany work in an assertive outreach setting. Many of these attitudes are ones which, in all probability, you already possessed before being hired for this job, and which, in fact, probably contributed to your being hired. However, some of the following attitudes will develop as you continue your career as an assertive outreach worker. The first of these attitudes consists of maintaining an **understanding that the difference between yourself and your clients is simply one of degree, not of "kind."** If you do not already feel this way, as your exposure to persons with mental illness who are homeless grows, you will begin to relate to clients as persons who have merely gone through different sets of experiences than yourself, but whose feelings, hopes, fears, and dreams are quite similar. This type of attitude entails becoming comfortable with mental illness and with homelessness and coming to the realization that these misfortunes can befall any of us.

A second attitude that is essential to maintain in regard to clients is a **respect for their struggles to overcome obstacles presented by their illness.** Holding such a respect for clients means taking the time to find out from them some of the experiences that they have been through as a result of having mental illness or of being homeless. It also includes making an attempt to understand and appreciate the fact that clients have survived an inordinate amount of stress because of being undomiciled and having mental illness. Clients deserve recognition for the strength that they have shown in meeting their difficult obstacles head on.

Another attitude that you should acquire while working in this assertive outreach position is the **belief that clients are** (or should be helped to become) **self-determining agents of their own change.** It can be easy to succumb to an urge to "take over" for clients and to make all the decisions for them. However, this urge is at cross purposes with the ultimate goal of helping clients attain independence. If clients are not in positions to decide their own fates, you should actively begin moving them in this direction.

Being open to the perspectives of other professionals is a fourth attitude that is imperative when working in an assertive outreach setting. This openness to other professionals includes the following: a willingness to negotiate with other team members and/or professionals in development of client treatment approaches; listening to and learning from other professionals and incorporating their ideas into your plans for clients; developing a shared sense of responsibility for clients with other professionals who are involved in clients' cases; maintaining a sense of humbleness about your ideas for clients; and always remaining open for suggestions from others.

Another attitude that is particularly applicable in a setting where assertive outreach is the main vehicle for reaching clients is a **willingness to look beyond the "dirty work" of case management** to the greater purpose of facilitating clients' adjustment in the community. Doing assertive outreach will bring you into various environments and situations, some not as pleasant as others. Therefore, it is necessary to learn to deemphasize some of the more negative details of assertive outreach -- the "ugliness" of the SRO's and state hospitals, delousing clients, helping them do laundry -- and to focus instead on the many positive aspects of the job and on the main goal of assisting clients in their adjustment to the community.

Along the same lines, a necessary attitude for doing assertive outreach with individuals who are homeless and have mental illness is a **willingness to work with people in poverty.** Because of the nature of homelessness, and often of mental illness, your clients will, in most cases, have little or no income and may live in the most destitute of conditions. A willingness to work with people in such situations and a desire to help them better their life circumstances is a must.

Finally, it is important to strive **to avoid the need to create "successes" for personal ego gratification.** Client needs take precedence in your daily work. Your ultimate goal is to assist clients in building on their strengths and you will want to help them to create successes for themselves. You then will be striving for a truer sense of altruism in your relationships with clients. This entails attempting to separate your feelings about the job from client success, so that you can obtain enjoyment from the

daily tasks of the job even when you see no immediate "successful" response. This type of attitude also encompasses a desire to work with all clients, regardless of whether or not they seem responsive or challenging.

Education/Experience

There are no agreed upon educational or experiential requirements for a position in an agency utilizing the assertive outreach model. Each agency seems to have its own set of requirements, depending on a number of factors, including what various funding sources dictate. In most settings, a college degree (with a strong background in psychology, sociology, or social work) or college classes in any of the human services, is beneficial but not absolutely necessary. However, some agencies do require a college degree as the minimum amount of education acceptable for an assertive outreach case manager position. In any event, an introduction to mental health issues in a formal, academic setting may be a useful first "exposure" to mental illness. Nevertheless, formal credentials are often less important than some of the personal characteristics and attitudes discussed above, coupled with a genuine desire and willingness to learn about and work with persons who have mental illness.

Prior social service experience, either paid or volunteer, will be valuable in your new position as an assertive outreach worker. If you have had previous experience in either a traditional or non-traditional social service setting, preferably with a mental health orientation, most likely you will have gained important information about working with persons who have mental illness. Certainly there is no better learning tool for working in an assertive outreach setting than prior "hands-on" experience.

Another important type of experience which will stand you in good stead in your new job is prior experience working as part of a team. Even if your agency functions in such a way that each case manager has his or her own individual caseload, teamwork is an essential component of assertive outreach. Hence, it is necessary to have both the ability and the desire to be a "team player." Having had prior exposure to a team setting in a previous place of employment will be helpful. However, even having been exposed to a team philosophy through participation in team activities will benefit you as you attempt to adjust to your new environment.

Perhaps one of the most beneficial kinds of experiences for your new position as an assertive outreach worker is to have had prior exposure to persons with mental illness. Although personal life experiences are not a replacement for professional training, familiarization with persons with mental illness leads you to be more comfortable working with them which, in turn, helps clients to be more comfortable with you.

Consumers as Assertive Outreach Workers

Until recently, the mental health movement has regarded consumers of its services as simply that, consumers. However, a relatively new outlook has developed in the field within the last decade and, as a result, both the mental health field and the general population are slowly beginning to recognize that mental health consumers are capable of doing more than merely using services. The consumer empowerment movement has sprung up, which recognizes individuals with mental illness as persons with all the rights, opportunities, and responsibilities accorded other citizens. Consumer empowerment also involves creating opportunities to help consumers develop their potential.

It is possible that you have been a consumer of mental health services in the past, or that one or more of the workers in your new office is a current or previous mental health consumer. It is important that you understand the implications of the consumer involvement movement. Consumer involvement is particularly pertinent in the assertive outreach field, where the "consumer voice" becomes especially important. Obviously, mental health consumers know better than anyone what is needed by individuals with mental illness who are homeless, although they are not often in a position to articulate this knowledge. However, consumers are becoming increasingly more active participants in service implementation, conduct of research, and design of public policy.

Besides the importance of listening to the consumer voice in the mental health field, consumer involvement in assertive outreach is also essential because of a consumer-cited need for peer support. Many consumers of mental health services spend much of their time alone after deinstitutionalization, and rehospitalization is often due to loneliness or need for companionship rather than compelling psychiatric reasons. Therefore, involving consumers in the assertive outreach field not only allows those who are working to develop their potential, but it also provides consumers with much needed peer support.

Another advantage to utilizing consumers in assertive outreach positions is that they are trained already in the mental health field through first-hand experience. Having gone through situations in the past which are similar in nature to those of clients gives consumers added knowledge and empathy. Also, having actually been in the mental health system themselves provides consumers with extensive knowledge of the system.

Assertive outreach workers who are also consumers should display the qualifications, personal characteristics, and attitudes desired by your agency, and should be stable enough so that their effect on clients is a positive one. However, formal academic training may be even less important in their cases because of the value of their personal life experiences.

UNIT 2

Setting the Stage: Introduction to the Client Population and the Model of Assertive Community Treatment

Introduction to the Client Population

Arriving at a standard, operational definition of the "homeless mentally ill" is an especially difficult task. Researchers use many different criteria to define both homelessness and mental illness (Santiago et al., 1988). In addition, highly diverse populations have been sampled (i.e., Vergare & Arce, 1983; Fischer et al., 1984; Lipton, Sabatini, & Micheels, 1986). Some consider an individual homeless if he or she has been undomiciled for only a few days; others look for recurring patterns of homelessness. Similarly, some researchers do not classify an individual as having mental illness until he or she has actually been hospitalized for psychiatric reasons, while others use less rigid criteria.

Due to the difficulties of reaching a standard definition of the homeless mentally ill, the estimates of the number of these individuals vary widely. Estimates indicate that between 1/5 and 1/3 of individuals who are considered to be homeless have also been hospitalized for psychiatric reasons (Bassuk & Lamb, 1986). However, the actual numbers of persons with mental illness who are homeless have been estimated to be anywhere between 500,000 and 1,000,000 (Drake, Wallach, & Hoffman, 1989).

There are a number of different characteristics of the population of individuals who are homeless. First of all, the overall population can be broken down into the following subgroups: individuals with serious mental illnesses; persons with substance abuse problems; people recently released from prisons; runaway and "throwaway" youths; and recent immigrants. Second, there seems to be an overrepresentation of African-American and Native American individuals among the homeless. Third, the average age for homelessness today is lower compared to previous periods of homelessness (Rossi et al., 1986; Stevens et al., 1983). Fourth, a large number of individuals who are homeless are not receiving the benefits to which they are entitled which may, in turn, be contributing to their continued homelessness (Rossi et al., 1986). Fifth, persons who are homeless exhibit a wide range of medical problems which are either directly caused or exacerbated by homelessness (Brickner et al., 1985; Wright et al., 1987). Finally, estimates of mental illness among persons who are homeless have reached as high as 90%, with 40% of these individuals evidencing major mental disorder (Bassuk, 1983; Roth et al., 1985; Rosnow, 1985; Torrey, 1989).

As with any other subgroup of individuals who are homeless, the reasons for homelessness among persons with mental illness vary. One of the major reasons for homelessness among this population is deinstitutionalization without the necessary levels of community after-care (Bachrach, 1976, 1978, 1980, 1983; Lamb, 1984). There has been a lack of attention to the actual needs and functional capacities of different groups of persons with persistent mental illness. In a sense, the community mental health system was developed around an idea of the "ideal" client, one who would actively seek services and show progress. As a result, the system is not well equipped to assist those who are noncompliant with treatment. For those individuals who will not readily seek out care from a community mental health system, more planning for long-term case management, psychosocial rehabilitation, and supportive services are necessary to keep these persons from becoming homeless (Bachrach, 1976).

Economic factors also contribute to homelessness among persons with severe mental illness (Lamb & Grant, 1982; 1983). Not only is there a lack of affordable housing in most major towns and cities in this country, but there is also a low utilization of benefits among persons with mental illness who are homeless, due to the difficult application process (Appleby & Desai, 1987). A certain degree of stabilization is necessary in order to make an initial application for benefits and to follow through with the application process: one must organize fairly extensive documentation to bring to interviews; one must be able to attend a number of interviews in a timely fashion; and, in order to receive notification about benefits throughout the application process, one must have a stable address even if it is a post office box.

The diagnoses, number of psychiatric hospitalizations, and patterns of substance abuse among persons with mental illness who are homeless vary widely. Perhaps the most common psychiatric diagnosis seen in this population is schizophrenia. Although there are actually five different subtypes of schizophrenia, you probably will work most with persons who have a diagnosis of either a paranoid or an undifferentiated type. Bipolar disorder, also known as manic depression, is another common diagnosis among persons with mental illness who are homeless. Schizoaffective disorder, where the individual exhibits disorders of both thought and mood, is another diagnosis that you will frequently see in your job as an assertive outreach worker. Personality disorders also are prevalent. Persons with a diagnosis of personality disorder might have a primary diagnosis of either schizophrenia or bipolar disorder, or they may only exhibit symptoms of a personality disorder. Among the various types of personality disorders, borderline personality disorder not only seems to be the most prevalent among those with mental illness who are homeless, but it is also a difficult disorder with which to contend. Finally, major depression is also seen among the individuals in this population, and it can be either endogenous

(a biological depression exhibiting itself as a chemical imbalance within the individual's system) or exogenous depression (depression exhibiting itself in reaction to the conditions of homelessness).

The number of psychiatric hospitalizations for persons with mental illness and homelessness is consistently high (Bachrach, 1976). Rehospitalization rates for persons with mental illness are as high as 30% to 40% within six months of discharge, 40% to 50% within one year of discharge, and 65% to 75% within three to five years of discharge (Anthony et al., 1972, 1978; Witheridge, Dincin, & Appleby 1982a). This problem of high recidivism exists in Illinois as well; in this state, 6.8% of those with mental illness were rehospitalized twice in one year; 2.5% were rehospitalized three times in a year; and 2.8% were rehospitalized more than three times, some with between ten and fourteen readmissions in one year (Kerr & Fullilove, 1978).

Substance abuse also is a problem for an unspecified but considerable number of persons with mental illness who are homeless. Possibly as high as 1 in 4 individuals within this population are dually-diagnosed; that is, they have both mental illness and substance abuse problems. It is difficult to separate the symptoms arising from mental illness from those arising from substance abuse. Long-term substance abuse can cause deficits in cognitive functioning, social skills, and behavior similar to those seen in persons with chronic schizophrenia (Kaufman, 1984). Therefore, as is the case in trying to operationally define the population of "homeless mentally ill," researchers have difficulty calculating the actual numbers of individuals who are dually-diagnosed.

Introduction to Assertive Community Treatment Philosophy and Objectives

There is a distinct philosophy behind the choice to treat clients using assertive outreach rather than in an agency-based setting. This philosophy was first developed by a group of mental health professionals in Madison, Wisconsin (Stein & Test, 1980; Stein, Test, & Marx, 1975) and adapted for use in inner-city areas by a program in Chicago, Illinois (Witheridge & Dincin, 1985; Witheridge, Dincin & Appleby, 1982b).

The first component of the assertive community treatment philosophy is an emphasis on the link between quality of life in the community and repeated psychiatric hospitalizations. In other words, assertive outreach workers firmly believe that if the quality of the client's life in the community improves he or she will have less need to be continually rehospitalized. Second is the belief that efforts must be targeted to those service recipients who have the greatest need.

Third, assertive outreach workers have a preference for an "in vivo" locus of intervention, so that service delivery contacts occur in the places where problems of everyday life arise for clients. This means that staff members can provide both support and skills training to clients in clients' own communities and personal settings. Fourth, advocacy is integral to the philosophy of assertive outreach. In fact, assertive outreach is based on the knowledge that staff must advocate for clients who are trying to negotiate system boundaries and bridge gaps between various service delivery systems.

Fifth, there is a preference in assertive outreach for anticipation of problems and use of preventative approaches, as opposed to reacting to problems once they have developed. In the same vein, in cases where crises are unavoidable, there is an emphasis on easy staff accessibility and rapid problem resolution. Finally, one of the major components of the philosophy that guides assertive outreach is the belief that clients need active help in coping with the stressful problems of everyday living.

In line with these aspects of the assertive outreach philosophy, the following are the main objectives of assertive outreach:

1. to improve quality of clients' lives in the community, in the hope of preventing extreme psychiatric recidivism and homelessness;
2. to work with clients who are in the greatest need, who might not otherwise be reached by more typical (i.e., client-initiated) social service efforts;
3. to maintain an "in vivo" locus of intervention providing support and skills training to clients in their own settings (i.e., home visits or visits to clients' neighborhoods) so that resolution of problems in everyday living takes place where the problems occur;
4. to advocate on behalf of clients in an effort to facilitate their negotiation of system boundaries;
5. to work on anticipating problems that clients may encounter, rather than reacting to problems that are already out of control;
6. to be easily accessible at times of crisis so that problems can be resolved rapidly; and
7. to help clients cope with the stressors of daily living.

Introduction to Assessment and Problem Solving

Two of the most important responsibilities you will have as an assertive outreach worker are assessing clients' problems and assisting them in finding ways to resolve their difficulties. These two functions may be considered the crux of assertive

outreach and are necessary because of the difficulties that clients experience in trying to negotiate tasks of everyday living. It is crucial for the assertive outreach worker to be able to assess client needs, to generate alternatives to help the client meet those needs, and to assist the client in choosing the best alternatives for getting needs met.

When targeting needs, you and the client will have to decide together which of the needs are immediate, which are short-term, and which are long-term. Immediate needs generally consist of the most basic necessities such as shelter, food, and clothing. Short-term needs might include obtaining consistent medical and mental health attention or securing permanent benefits. Long-term needs might consist of involving the client in a psychosocial or vocational rehabilitation program. However, the most important thing to keep in mind when targeting a client's needs is that you must continually determine which needs are ones that, if not met, will put the client's life in jeopardy. Those are the needs that will take priority as you begin working with a client.

Within each of the need categories -- immediate, short-term, and long-term -- you can prioritize various needs. You and the client should determine which of the immediate, short-term, and long-term needs takes priority over the others. Once each need category is prioritized, you can implement a plan to have the most crucial needs met first.

There are some unwritten rules dictating how and when to handle clients' needs. Immediate needs are almost always handled during visits to the client within the community or from the staff office by advocating for the client via telephone. You must be flexible enough to be able to respond to problems on-the-spot. For instance, if you go to visit "Sue," and she tells you that she is completely out of food, you could either take her to a shelter that distributes food boxes, or you could drive her to a shelter that serves free meals. No matter how you respond, however, the important thing is that you do so immediately. Being flexible enough to respond to immediate needs during each community visit means that, in many cases, you will not be able to follow a pre-established itinerary for each client visit but, instead, will need to make room for crises.

Short- and long-term needs leave more room for planning. These needs usually should be discussed in the office with the rest of your assertive outreach team, after getting input from the client. With the team, you can map out the details of how and when to meet client needs that cannot be handled immediately. In your service plans for clients, set firm deadlines for meeting short- and long-term needs so that you do not lose sight of them in the midst of immediate needs.

Role of the Assertive Outreach Worker

Your role as an assertive outreach worker will be a multi-faceted one. This role will require you to draw upon many inner resources and past experiences in addition to learning many new and valuable skills. One of the aspects of your role as an assertive outreach worker will be to **identify members of your target population.** This includes being able to assess whether or not prospective clients meet eligibility criteria (i.e., are truly in the greatest need of attention from a core services team of assertive outreach workers). Identifying members of the target population also entails maintaining good relationships with major referral sources so that clients will be referred for intake into your agency.

Persons with mental illness who are homeless will be referred to your agency (or to similar assertive outreach agencies) from a number of different sources. State-operated facilities are one of the major referral sources for social service agencies providing case management. Because mental health workers in these facilities are legally obligated to document that patients being discharged from their facilities have a place to go after discharge, these workers will often contact case management agencies when they are discharging a patient who is homeless. Community mental health centers are another referral source for an assertive outreach program; if a client is coming in for mental health care who needs more extensive follow-up than weekly visits to a social worker and monthly visits to a psychiatrist, an assertive outreach agency may be contacted.

Both day-time and overnight shelters are another common referral source. In all probability, your agency has established links with various shelters throughout the city. These facilities will contact your agency when they encounter clients who they feel are appropriate for assertive outreach. Similarly, single-room occupancy hotels (SRO's) also may contact your agency when they receive clientele with psychiatric disabilities who seem to be in need of some extra assistance.

Employees at bus terminals and airports are often sources of referrals to your agency. These persons may be employees either of Traveler's Aid or the transportation company. They may or may not have experience with the person who is homeless and has a mental illness. However, they are in a position to spot individuals needing assistance. Your ability to liaison and relate to them will serve client needs as well as your agency's purpose in the community.

Finally, the families of persons with mental illness who are homeless, or the individuals themselves, may contact your agency seeking services. In cases where an individual is referred by a family member, it is important to maintain connections with the

family, if possible, to let them know how the client's treatment is proceeding.

Another facet of your role as an assertive outreach worker entails **engaging the new referrals** in the program. The initial engagement of a new client must be slow and careful, so that the client will not be overwhelmed by your offer of assistance. It is essential to remember that many clients have been homeless and without help for a very long time and might need to move into their new relationship with you gradually. Ideally, you should initially engage a new client by assisting him or her with a concrete task, in order to demonstrate the advantages of participation in a case management program from the outset.

A third task involved in your new role as an assertive outreach worker is **conducting assessments** and, subsequently, **planning interventions** based on these assessments. Conducting an assessment consists of taking stock of a client's strengths, difficulties, existing resources, and remaining needs. Based on an assessment of the client, you will then search out novel ways to interrupt the chain of events that previously led to the person's distress in the community and subsequent rehospitalization or homelessness. In consultation with the client, and his or her family if the client consents, you will develop an intervention strategy, modifying the strategy along the way if need be.

In your position as an assertive outreach worker, you will assume ultimate **professional responsibility for clients.** This includes helping clients assemble coherent, individually tailored packages of community supports, which are provided either directly by the assertive outreach team at your agency or set up by the team in conjunction with other service providers. Assuming ultimate professional responsibility for clients also means showing unusual tolerance for "unresponsive" or "difficult" behavior and refusing to "give up" on clients.

Home visiting is the hallmark of assertive outreach. In your role as an assertive outreach worker you will meet with individuals on their own turf, where their problems generally arise and where the solutions to their problems must be found. In order to effectively fulfill this part of your role, you must have the flexibility to meet with clients in very unconventional places: low-rent hotels, welfare offices, public shelters, police lock-ups, street corners, and neighborhood coffee shops, to name a few.

Attending to the **concrete details of clients' everyday lives** is a sixth aspect of your new case manager role. You must pay close attention to matters of everyday living that might otherwise be taken for granted such as food, clothing, shelter, medical care, entitlements, and money management. Because clients may have difficulty getting these basic needs met, your assistance will help make concrete matters seem less

overwhelming. Subsequently, if the concrete details of everyday living are more manageable, then living in the community becomes, for clients, a viable and desirable alternative to institutional care.

Part of the manner in which you will attend to the concrete details of clients' everyday lives is by providing clients with **in vivo assistance and training.** Your role as an assertive outreach worker will include giving on-the-spot help and skills training to clients regarding a wide range of independent living tasks, such as grocery shopping, laundry, leasing an apartment, managing a checking account, or cleaning a room. You also can encourage clients to become involved in social, vocational, recreational, and self-help programs and can even attend the first few meetings of these programs with clients, in an effort to facilitate their pursuance of higher-level goals.

Another responsibility included in your new role consists of **arranging for psychiatric and other medical services** for clients. Because arranging for psychiatric and medical visits and follow-ups is often confusing and even stressful, one of your new duties will be to take an active role in helping clients obtain the highest quality services available. In some cases, you will merely be assisting clients in arranging the visit; in others, you will have to physically accompany clients to their doctor or psychiatrist appointments in order to help clients negotiate the entire process.

Another major part of your role as an assertive outreach worker is to **provide interagency resource brokering and advocacy.** By functioning as an all-purpose resource broker, you will be facilitating efforts by the many private and governmental agencies on which persons with psychiatric disabilities depend, in order to make clients' negotiations through various systems run more smoothly. You may have to expend much time and energy advocating on the behalf of clients as they confront the many bureaucracies to which they must turn for help. This advocacy may very well be one of the most important aspects of your service to clients.

Along with advocating on behalf of clients to existing resources and providing interagency resource brokering, you may also be called upon to **develop new community resources** for your agency. This could entail searching for, and making available to clients, hidden resources, or possibly developing currently nonexistent resources "from scratch." When a client has a certain need which cannot be met by an existing resource, you may have to creatively combine resources in order to come up with a new avenue for addressing the need.

Although one of the goals of assertive outreach is to ensure that clients can live comfortably in the community without having to call upon assistance from inpatient psychiatric units, there will be times when a psychiatric hospitalization is both

appropriate and necessary. When this type of situation occurs, your role will include **facilitating the hospital readmission** and **working with the inpatient staff** while the client remains in the hospital. This aspect of your role consists of the following: being able to recognize signs that the client is truly in need of rehospitalization; initiating hospitalization if the client is unwilling to go voluntarily; and working with inpatient staff once the client is safely hospitalized in order to have a voice in the client's inpatient treatment and to take part in his or her subsequent discharge plans.

Finally, in the course of your work in this assertive outreach role, you will want to **establish a partnership with families of clients**, in cases where client and family are still in contact and the relationship between client and family is one that has potential to be of some benefit to the client. Working in partnership with families means expanding the advocacy role to include activities on behalf of clients' families. Except in cases where the relationship between client and family seems severely destructive, you should view family members as partners, not as adversaries.

UNIT 4

Physical Well-Being: Introduction to General Health Issues among Homeless Persons with Severe Mental Illness

General Medical Care

A wide range of medical problems exist that are directly caused by homelessness or are exacerbated by being undomiciled. The reasons for the tendency toward poor health among individuals who are homeless are numerous. First of all, having no shelter from the elements exposes persons to a great deal of inclement weather; often, these individuals are unable to obtain clothing that is suitable for the temperature. Second, being undomiciled and having few (or no) benefits makes it nearly impossible to find a way to eat regular, well-balanced meals. Third, whether staying in the shelter system or living on the streets, persons who are homeless are not always in a position to maintain proper personal hygiene and, thus, may be exposed to more germs and viruses. Along the same lines, being forced to reside in places where living conditions are extremely unsanitary also increases the chances of having poor health.

Another major factor contributing to the extensive range of medical problems plaguing persons who are homeless is the difficulties that these individuals encounter when trying to access medical care. If a person is not insured through private insurance or is unable to pay, he or she must have either a Medicaid or Medicare card in order to receive medical attention. However, many persons with mental illness who are homeless are unable to obtain a Medicaid or Medicare card without help because of the difficult application process. Many have lost benefits that were previously established. Hence, these individuals may go without any type of medical services. Also, making arrangements to receive good medical care requires a certain level of stability that is difficult for individuals who are homeless to attain: 1) they must have access to a phone so that they can make and receive calls to arrange medical appointments; 2) they must have money for public transportation in order to be able to get to the medical clinic; 3) they must be able to understand and follow medical instructions; and 4) they must be able to attend follow-up appointments.

Dental Care

Lack of a stable domicile also makes it difficult for an individual to care for his or her teeth. Not only does being undomiciled make it nearly impossible to brush daily, but making and keeping regular appointments for dental check-ups is difficult. Because of hindrances faced by persons who are homeless, often they have severe and painful dental problems which may result in loss of teeth.

For individuals who are homeless, accessing dental care is a problem equal in magnitude to obtaining medical care. In fact, very few private dentists will honor a Medicaid card. It is important that your agency keep a running list of those dentists who will accept Medicaid, so that you can quickly assist a client when he or she is in need of dental care. If there are no dentists in your area willing to accept Medicaid coverage, look for a dental school, a dentist who will offer a payment plan, or a dentist who is willing to barter for services.

Podiatry

Podiatry is another service that persons who are homeless may be in need of, but which may not always be readily accessible. Being homeless can create problems which require the services of a podiatrist for a number of reasons. First of all, since individuals who are homeless have little money, often they must buy second-hand shoes from a thrift shop or accept them from a shelter. These shoes may be ill-fitting or in poor condition and may not provide the proper support to feet. Second, if an individual is unable to afford public transportation, he or she will be forced to walk as the sole means of transportation. In poorly fitting shoes, a great deal of walking can be hard on an individual's feet. Finally, persons who are homeless are often forced by law enforcement agents to "keep moving" in order to avoid being arrested for loitering; hence, these individuals may be forced to walk from place to place all day long.

If one of your clients has severe problems with his or her feet, you will need to find a podiatrist who will honor a Medicaid card, as foot problems are not ones which should be ignored. Once you (or another assertive outreach worker at your agency) discovers a good podiatrist who will accept your clients, add his or her name to the agency resource list for future reference. Again, if you cannot find such podiatrists, look for a podiatry school, a physician willing to barter or donate time and services, or an office willing to set up a payment plan.

Nutrition

Poor nutrition is another medical problem that is common within the homeless population. Part of the problem facing these individuals stems from not having enough money to eat consistent, properly nourishing meals. Moreover, homeless individuals may not have places to store food or prepare meals. In addition, persons who are homeless may be poorly educated about nutrition and may not be aware of which foods are healthy. It is important that you take time to talk to clients about nutrition. If you take them grocery shopping, make sure that you point out the more nourishing foods.

For individuals with mental illness who are not only homeless but also chemically dependent, nutritional problems will be compounded. In the more severe stages of alcoholism,

individuals let drinking take precedence over eating and may even *forget to eat. Also, persons who have persistent substance use* disorders often are depleted of major vitamins and minerals; these individuals must have large doses of vitamins prescribed for them by physicians or psychiatrists.

In your job as an assertive outreach worker, you should become aware of standard nutritional guidelines. You will then be in a position to advocate for healthier food alternatives in shelters, drop-in programs, and other places which serve meals. As you encounter food drives and community organizations attempting to assist persons with mental illness who are homeless, make suggestions that will encourage donations of nutritional items for your clients.

AIDS and HIV Infection

As is the case with the general population, persons with mental illness who are homeless are at risk for infection with the AIDS virus (HIV). Unfortunately, efforts to educate persons about the prevention of HIV infection may not reach homeless individuals with mental illness to the same extent that they reach the general population (Lyons & Cook, 1989). The primary reason for this lack of access to AIDS prevention information is that homeless individuals have limited access to the mass media. Also, the education level of those with mental illness who are homeless is often lower than that of the general population, preventing them from comprehending information about the virus and its transmission (Lyons & Cook, 1989).

Certain factors may put homeless individuals with mental illness at greater risk for HIV infection than the general population (Lyons & Cook, 1989). First, individuals with mental illness have residual social impairments which may interfere with following "safe sex" guidelines; thus, they may lack some of the social skills necessary to deal with sexual relationships. Moreover, because of their poor social skills, it may be particularly difficult and anxiety-provoking for persons with mental illness to introduce safe sex practices into their sexual encounters. Second, opportunities for sexual experiences among persons with mental illness may be fewer due to their low level of social acceptance by the general population. This may make these individuals less likely to pay attention to safe sex guidelines when encounters do occur. Also, because of their low level of social acceptance, the population of persons with mental illness may be a relatively closed network sexually, which would make the opportunity for transmission within this subculture quite high once the infection is introduced.

Third, if persons who are homeless are dually-diagnosed (have both mental illness and substance use disorders), and have taken drugs intravenously (i.e., IV drug use), they will have a greatly increased risk of exposure to HIV infection. Moreover, the use of alcohol and drugs during sexual activity is associated with greater likelihood of unsafe sexual practices which, again, increases the risk of exposure. Finally, persons who have mental

illness and are homeless may be at great risk for contracting the AIDS virus because their poor physical health may lead to lower levels of immunity, which could predispose them to greater likelihood of HIV infection upon exposure to the virus.

As part of your job, you will want to attend seminars and discussions about AIDS and HIV infection which will enhance your own understanding of the issues. Discuss with your team the option of making condoms available to your clients. Learn the most effective techniques of demonstrating condom use and share them with your clients. Be aware that demonstrating and then simulating correct condom use has been identified as the most effective means of education. Many AIDS education techniques involve demonstrating how to put on and remove a condom, using an appropriately shaped object such as a banana. Be sure to include your female clients in this education and to discuss with them their need to **negotiate** assertively condom use with their partners. Involve yourself in discussions about confidentiality and guidelines for health care precautions related to HIV infection. Become familiar with AIDS education and treatment resources. Make an AIDS information hotline number available to your clients, and distribute appropriate literature.

UNIT 3

Features of the Disability: Introduction to Mental Illness and Substance Use Disorders

Overview of Symptomatology and Treatment

As you continue your work in the assertive outreach field, you will need to become increasingly familiar with mental health issues. It is imperative that you become familiar with common mental health terminology, including symptoms and treatment of various psychiatric disorders. You will need to be able to converse with many different individuals in the mental health field -- including psychiatrists and psychologists -- about your clients' symptoms and treatment.

Following are descriptions of the common symptoms of various forms of mental illness (adapted from the Diagnostic and Statistical Manual of Mental Disorders --Third Edition - Revised, 1987). In our descriptions, we have quoted from the DSM-IIIR in an effort to present their criteria as accurately as possible. Space limitations prevent a complete description of each of the commonly encountered psychiatric disorders. Please consult with your agency psychiatrist, physician, team members and others in the mental health field. Their practical information and input will be invaluable. Also be sure to read and periodically consult the Diagnostic and Statistical Manual.

Symptomatology

Schizophrenia has an earlier onset than some of the other psychiatric disorders, usually becoming apparent in an individual by the late teens or early 20's. During some phase of the illness Schizophrenia, you will see delusions, hallucinations, or certain characteristic disturbances in affect and the form of thought.

There are five major types of Schizophrenia. Associated features of **paranoid** type include: unfocused anxiety, anger, argumentativeness, and occasionally dangerous behavior. In your job as an assertive case manager you may notice suspiciousness, frequent auditory hallucinations related to a single theme, or difficulties in interpersonal interactions.

Schizophrenia of a **Catatonic** Type is distinguished by marked psychomotor disturbance such as stupor and rigidity, among others. You may also see posturing and voluntary assumption of inappropriate or bizarre postures. Alternation between excitement and stupor is also common, as is mutism.

Disorganized, or Hebephrenic, Schizophrenia typically has an early onset and carries a chronic course without significant remissions. The essential features of this type are incoherence, marked loosening of associations, grossly disorganized behavior, and inappropriate affect. Social impairment and oddities of behavior are common. Fragmentary delusions and hallucinations without a coherent theme are seen.

When diagnosed as having Schizophrenia of an **Undifferentiated** nature, the individual meets the usual criteria for Schizophrenia (delusions, hallucinations, thought disorder, and bizarre behavior) but does not clearly fit into any one subtype because of a mixed symptom picture.

Finally, Schizophrenia of the **Residual** Type is characterized by common signs of Schizophrenia, such as emotional blunting, social withdrawal, eccentric behavior, illogical thinking, and mild loosening of associations, without prominent psychotic symptoms.

The Mood Disorders are also commonly seen among persons with mental illness who are homeless. The Mood Disorders are divided into Bipolar Disorders and Depressive Disorders. The essential feature of this group of disorders is a disturbance of mood, accompanied by full or partial manic or depressive syndrome.

Bipolar Disorder is distinguished from Major Depressive Disorder by the presence of at least one episode of mania in the history of the individual's illness, and an individual with bipolar disorder often cycles between mania and depression.

The symptoms for mania can be distinguished by a persistently elevated, expansive or irritable mood. You may notice inflated self-esteem or grandiosity; decreased need for sleep; flight of ideas and racing thoughts; excessive involvement in pleasurable activities which have high potential for painful consequences (buying sprees and sexual indiscretions).

Major Depressive Disorder may begin at any age. The following symptoms characterize Major Depression: a depressed mood, most of the day, nearly every day; markedly diminished pleasure in all activities, nearly everyday; significant weight loss or weight gain; insomnia or hypersomnia; recurrent suicidal ideation; psychomotor agitation; feelings of worthlessness or excessive inappropriate guilt.

Some individuals with mental illness have either a primary or secondary diagnosis of one of the many types of **Personality Disorders**. Diagnostic criteria refer to behaviors or traits that are characteristic of the person's recent and long-term functioning. The behaviors cause either significant impairment in social or occupational functioning or subjective distress.

The essential feature of a **Paranoid Personality Disorder** is a pervasive and unwarranted tendency, present in a variety of contexts, to interpret the actions of others as deliberately demeaning or threatening. Persons with this disorder feel exploited or harmed by others. Frequently they will question the trustworthiness of others, harbor jealousy, are easily slighted and quick to react with anger, and are reluctant to confide in others fearing the information may be used against them.

Persons diagnosed with a **Schizoid Personality Disorder** have a pervasive pattern of indifference to forming social relationships and a restricted range of emotional experience and expression. They prefer to be "loners." They most always choose solitary activities and are indifferent to praise and criticism.

Individuals with a **Schizotypal Personality Disorder** exhibit a pervasive pattern of peculiarities of ideation, appearance, and behavior, as well as deficits in interpersonal relatedness. You may see ideas of reference, excessive social anxiety, magical thinking, unusual perceptual experiences, odd speech, or suspiciousness.

The essential feature of the **Borderline Personality Disorder** is a pervasive pattern of instability of self image, interpersonal relationships, and mood. You will notice a marked, persistent identity disturbance. Your client will appear to be uncertain about several life issues, goals, friends, and values. Affective instability is common. Recurrent suicidal threats and gestures are common in the severe forms of the disorder. Frequent displays of temper, anger, and recurrent fights may be present as well.

A **Histrionic Personality Disorder** is characterized by excessive emotionality and attention seeking. Persons seek and demand reassurance, approval, or praise, and are uncomfortable when they are not the center of attention. They display rapidly shifting and shallow expression of emotions. Their behavior is overly-reactive and intensely expressed. There is a tendency to be very self-centered with little tolerance for the frustration of delayed gratification.

Individuals diagnosed with a **Narcissistic Personality Disorder** will display a pattern of grandiosity, hypersensitivity to the evaluation of others, and lack of empathy. Persons will display an exaggerated sense of self-importance and exaggerate their accomplishments and talents. Self-esteem is almost invariably very fragile and feelings are masked with an aura of cool indifference.

Persons with **Antisocial Personality Disorders** show a pattern of irresponsible and antisocial behavior. They must be at least 18 and have a history of conduct disorder before the age of 15. Lying, stealing, truancy, vandalism, and fights are typical childhood signs. The pattern continues in adulthood and may

include failure to honor financial obligations, to function as a responsible parent, or to sustain consistent work behavior. These persons fail to conform to social norms and repeatedly perform acts that are grounds for arrest. They tend to be irritable and aggressive. Generally, they have no remorse about the effects of their behaviors on others.

Individuals diagnosed with an **Avoidant Personality Disorder** show social discomfort, fear of negative evaluation, and timidity. They are easily hurt by criticism and devastated by the slightest hint of disapproval. These persons generally are unwilling to enter into relationships unless they feel a guarantee of uncritical acceptance.

Dependent and submissive behavior is the essential feature of a **Dependent Personality Disorder**. Persons with this disorder are unable to make decisions without excessive advice and reassurance. This tends to lead to difficulty in initiating projects or doing things on one's own. A person with a dependent personality easily is hurt by criticism and disapproval and tends to subordinate to others, agreeing with people when they believe them to be wrong.

An **Obsessive Compulsive Personality Disorder** is characterized by perfectionism and inflexibility. Persons with this disorder show a preoccupation with rules and details, and this interferes with their ability to take a broad view. Work and productivity are prized, decision making is avoided. Persons are extremely conscientious, moralistic, and judgmental of self and others.

Individuals with **Passive Aggressive Personality Disorders** show a pattern of passive resistance to demands for adequate social and occupation performance. This resistance is expressed indirectly and results in persistent social and occupational ineffectiveness. Persons with this disorder resent and oppose demands to increase or maintain a given level of functioning. Resistance is expressed through procrastination, stubbornness, inefficiency, and forgetfulness.

Assessment of Mental Health Needs

In order to assist effectively in the treatment of persons with mental illness you must first make an accurate assessment of their mental health needs. One of the most important factors you will examine when conducting a mental health assessment is the client's psychiatric symptoms. **Assessing psychiatric symptoms** involves a number of steps. First, you must familiarize yourself with the client's history of symptoms. Ask the client, and his or her family, if possible, to give you a rendition of the history and current status of the illness. Also, write a letter to all of the psychiatric hospitals where you know the client has spent a period of time, asking them to send you the client's

hospitalization records. You must enclose a current release of information, signed by the client, granting you access to the files. Please make certain to check with your supervisor and co-workers regarding the guidelines in your state related to procedures for releases and confidentiality.

When you receive the records read them carefully, including any social histories that may be attached, so that you begin to see the pattern that the client's illness has taken over the years. It is helpful to attempt to fit the client's current situation, with which you should be somewhat familiar, into the context of the history of his or her illness. In this way, you can see whether the client has made any progress, whether his or her progress has stagnated, or whether he or she seems to have regressed over the years.

The second step to assessing the client's psychiatric symptoms is to make an assessment of the client's immediate psychiatric needs. You should try to determine if any of the client's symptoms are causing him or her to experience extreme, immediate discomfort and, if so, the nature of those symptoms. The client may be experiencing a flare-up of psychiatric symptoms, in which case he or she might be having acute exacerbations of delusions or hallucinations. It is also possible that a client is experiencing side effects from psychotropic medication and that these side effects are causing extreme discomfort. The client may also have such severe interpersonal skill deficits that the quality of his or her everyday life is impaired. Finally, when you are conducting an assessment of the client's immediate mental health needs, you also must make sure to note any prodromal symptoms or signs showing that the client is becoming psychotic.

The third step in an assessment of the client's psychiatric symptoms is taking stock of the client's short-term needs. It is helpful to list the symptoms that both you and the client feel can be tolerated until interventions can be initiated. This step entails learning to evaluate which symptoms are less serious and do not need immediate attention.

When making an assessment of psychiatric symptoms, an assessment of long-term needs is feasible. During this step of the assessment, you will make a list of the symptoms which you feel will require long-term interventions. Sometimes, when a client has multiple immediate and short-term needs, it is easy to lose sight of long-term goals. You should attempt to review periodically your assessment of the client's long-term needs so that these are not ignored in the presence of basic mental health necessities.

There may be times when your assessment of a client's psychiatric symptoms does not immediately call to mind viable treatment options, or when you realize that no interventions currently exist that will adequately meet your client's special

needs. In such cases, your options are either to help the client to at least maintain the status quo, so that his or her psychiatric symptoms do not worsen before more beneficial treatment options are created, or to actively try to develop new resources on your own, so that the client's needs can be met quickly. Consultation with trusted colleagues on your team or outside of the agency can be helpful in generating new options.

Crisis Assessment. Another factor to take into account when conducting a mental health assessment is whether or not the client currently is experiencing a situation that constitutes a crisis. The first step to assessment of crises involves evaluating whether a crisis is actually occurring. Sometimes it is difficult to separate situations that are merely out of the ordinary from those that are actual crises. However, the following are some guidelines to assist you in deciding whether or not a client is experiencing a crisis and, from there, if crisis intervention is warranted:

1. The client constitutes a danger to himself or herself (i.e., has made veiled or open references to suicide and seems to have a plan for carrying through the act);
2. The client is a danger to others (i.e., has made assaultive or homicidal threats);
3. The client is currently taking a medication that has the power to be toxic -- lithium, MAO Inhibitors, etc. -- and seems to be experiencing some symptoms of early medication toxicity;
4. The client tells you, or you notice, that he or she seems to be experiencing severe side effects -- acute dystonia, tardive dyskinesia, etc.;
5. The client is having severe allergic reactions to psychotropic medication; or
6. The client has overdosed on street drugs or alcohol or is experiencing other acute substance abuse effects.

Assessment as an information-gathering and goal-directing tool is an ongoing process. Periodically, you should update your information and review previous conclusions to monitor your treatment plans. As always, you must modify plans in conjunction with your client, team members, and supervisor.

Interventions Leading from Assessment

The interventions that you use with clients will vary, depending on your assessment of the situation. **Immediate intervention strategies**, where you are treating psychiatric symptoms that cause the client immediate discomfort, might include taking the client for an emergency visit to his or her treating psychiatrist or possibly even to the emergency room of a local hospital. Make certain that the client has access to a hotline telephone number, in the event that symptoms flare up when your team is not available immediately.

Short-term intervention strategies, where you and the client agree that the symptoms can be tolerated until treatment can be made, might include making a referral to the client's treating psychiatrist for adjustments in medication dosage, changes in medications, or changes from oral to injectable medication. When planning short-term intervention strategies, it is important to pay attention to what has worked for the client in similar situations in the past. Be sure to refer to previous hospitalization records for guidance.

Long-term intervention strategies are used to help the client meet some of his or her long-term goals and should be addressed after the client's concrete needs (food, shelter, clothing) have been met. Some examples of long-term intervention strategies are to get the client involved in a day treatment program, in a psychosocial rehabilitation program, in a vocational rehabilitation program, in group therapy, or in weekly individual counseling at a local community mental health center. It is essential that you pay attention to what has not been tried with the client before or to what has been tried under different circumstances. Sometimes trying a new intervention, or an old one with a slightly different twist, will suddenly click for the client and he or she will make a large improvement.

Crisis intervention strategies are probably the most difficult intervention strategies that you will be called upon to perform in your new role as an assertive outreach worker. The first thing to remember when faced with crisis situation is to try to remain as calm as possible. Especially in cases where clients in crisis are in severe psychotic states, it is imperative not to escalate with them; only by staying calm can you begin to help clients deescalate.

When you are with a client, and you realize that you have a crisis situation at hand (i.e., he or she is suicidal, homicidal, or is unable to care for himself or herself), you must prioritize calls for assistance. In most cases, the first call that you make will be to the police. (Make sure you tell the police if an ambulance also will be necessary.) If you believe that the client will need to be involuntarily committed, you must also contact the psychiatrist at your agency so that he or she can meet you to sign certification papers. You also may want to contact members of your assertive outreach team so that someone can come out to assist you at the scene of the crisis. Even if you do not feel it necessary for another team member to meet you, it is always helpful to receive advice and support from other team members via the telephone.

There may be instances when you call for assistance and it does not arrive. If this occurs, contact the police captain of the local station to explain the client's situation. Make sure that you tell him or her that you have put in a call for help but that no police persons have arrived. If you are waiting for help in close proximity to the client, and he or she appears to be

dangerous, leave the scene and try reaching the police from a telephone that is at a distance from the client. Be sure to check with the supervisor regarding your agency policies as well as local procedures pertaining to such instances.

When clients are either actively psychotic and constitute a danger to themselves or to others, or are unable to care for themselves but refuse to go to the hospital voluntarily, you will have to begin the process of involuntary commitment. The following is the standard procedure in Illinois to commit a client involuntarily. You should be sure to check with your supervisor regarding agency policies and typical practices in your own locality.

1. You must fill out and sign a petition documenting the client's behavior and why you believe he or she needs to be committed.
2. You must either bring a signed certificate filled out by the client's acting psychiatrist, or have the psychiatrist meet you so that he or she can fill out the certificate on the spot.
3. Call the police and explain the client's situation, being sure to tell them that you have, in your possession, signed petition and certification forms.
4. Wait at the address that you have given the police (client's residence, shelter, etc.) until they arrive, making sure you are at a safe distance from client if he or she appears angry or agitated (it is often necessary to wait outside).
5. When police arrive, escort them to the client, trying to reassure the client that he or she will not be hurt.
6. Once the client is safely on his or her way to the hospital, call the hospital to advise staff there in advance that your client will be coming and is in serious need of psychiatric attention (i.e., must be admitted upon arrival to hospital).

Hospital admissions constitute one of the clear instances that may require psychological processing of what assertive case managers see and feel, as well as how our attitudes affect ourselves and our ability to work with clients. Make an effort to think about how you handle this situation. Bring it to your team meeting where you can access support, advice, and reassurance. We will discuss these issues in greater detail later in the section on processing.

Treatment

Assertive outreach is one proven method of treatment for serious and persistent mental illness. Other treatments include milieu therapies, Lodge models, Club Houses, various types of counseling and/or therapy, self-help, and informal networks. We will discuss assertive case management in greater detail later in

this manual. Your co-workers and supervisors can assist you in identifying other treatment modalities available in your community. Professional journals will provide you with detailed descriptions of program models and research regarding different services available throughout the country. To aid you in identifying which journal articles or books you might like to read, we have included an Annotated Bibliography at the end of this manual. Most programs willingly share information if contacted. Remember to keep your personal resource list up to date; how to do this will be discussed further in a later section.

Psychotropic medications have been helpful for many individuals with severe and persistent mental illness. Psychotropic medications can work to calm a person with severe mental illness when he or she is in a psychotic state, can dispel an individual's delusions and/or hallucinations, and can help to stabilize an individual's mood. The following is a list of psychotropic medications and their concomitant types, uses, and side effects, taken from an excellent article by Waldinger (1986). For ease in location of information, the list is broken down into the major categories of medications: anti-psychotics, mood stabilizers, anti-depressants, anti-anxiety agents, and anti-side effect agents.

Commonly Prescribed Medications

A. Anti-psychotics
   1. Types
      a. Phenothiazine
         i. Thorazine
         ii. Serentil
         iii. Quide
         iv. Mellaril
         v. Tindal
         vi. Prolixin
         vii. Trilafon
         viii. Stelazine
      b. Thioxanthenes
         i. Taractan
         ii. Navane
      c. Dibenzazepines
         i. Loxitane
         ii. Daxolin
      d. Butyrophenones
         i. Haldol
      e. Indolones
         i. Moban
      f. Rauwolfia alkaloids
         i. Reserpine
      g. Clozaril

2. Uses

   a. To control acute, severe psychotic agitation, using an intramuscular injection
   b. To control acute episodes of illness, such as the recurrence of auditory hallucinations, using daily oral doses
   c. For maintenance therapy, to prevent recurrent exacerbations of the illness, using daily oral doses or intramuscular doses of depot medication every two to four weeks
   d. Also used for the treatment of acute manic excitement, amphetamine psychosis, drug-induced psychosis, agitated or psychotic depression, chronic brain syndromes, and anxiety (when other drugs have proven ineffective)

3. Side effects

   a. Sedation: occurs in 80% of cases but usually lasts about a week and can be treated by lowering dosage or giving entire daily dose at bedtime
   b. Extrapyramidal side effects (EPS)
      i. Dystonia: state of abnormal muscle tension which manifests itself in muscle stiffness or spasms
      ii. Parkinsonism: decreased movement and energy, shuffling gait, mask-like facial expression, and tremors
      iii. Akathesia: restlessness, rocking, and pacing
      iv. Akinesia (relatively uncommon): markedly decreased or absent body activity
      v. Tardive dyskinesia: most serious of side effects; often irreversible, although sometimes will disappear completely when medication is discontinued; includes involuntary movements, such as lip smacking, sucking, jaw movements, "fly-catching" tongue movements, writhing movements of the extremities, and occasional difficulty in swallowing
   c. Lowered seizure threshold: increased likelihood of seizures in people who have preexisting seizure disorders
   d. Anticholinergic side effects: dry mouth, blurred vision, nasal congestion, rapid heart beat, and constipation, which are all usually mild and disappear within days or weeks; occasionally more severe, such as paralysis of the intestines or urinary retention
   e. Postural hypotension: sudden and large drop in blood pressure -- may result in fainting

f. Allergic or toxic side effects (uncommon)
   i. Agranulocytosis: decrease or absence of white blood cells in circulation; occurs within first 3-8 weeks of treatment to approximately 1 in 5,000; treated by stopping all medication
   ii. Dermatitis: skin rash, as a reaction to the drug and to the drug-induced sensitivity to sunlight
   iii. Allergic hepatitis: occurs mostly with Thorazine to 1 in 500 during the first four weeks of treatment; remits when drug is stopped
g. Metabolic or endocrine side effects: weight gain, menstrual irregularity, abnormal production of breast milk and breast enlargement, high blood sugar, and elevated or decreased body temperature
h. Toxic retinopathy (caused only by Mellaril in dosages of more than 800 mg per day): damage to the retina of the eye
i. EKG changes (more common with Mellaril): arrhythmias, T-wave inversions, and changes in QRS intervals
j. Retrograde ejaculation (caused primarily by Mellaril): ejaculation of semen up into the man's urinary bladder instead of out of the penis through the urethra

B. Mood stabilizers

1. Types
   a. Lithium

2. Uses

   a. To control acute mania (works in roughly 80% of the cases, after a 1-2 week "lag period")
   b. To prevent relapses of both manic and depressive episodes in bipolar illness
   c. To prevent recurrent depressive episodes in people with unipolar depression (studies have shown its effectiveness in treating this disorder, but lithium has not yet been approved by FDA for use in unipolar depression)
   d. Of limited use in treating schizoaffective disorder

3. Side effects

   a. Early side effects
      i. Gastrointestinal distress (nausea, vomiting, diarrhea, stomach pain)
      ii. Muscle weakness
      iii. Subjective experience of being dazed/tired

iv. Hand tremor
v. Increased thirst and frequency of urination

b. Later side effects
i. Persistent hand tremor
ii. Severe and persistent increased thirst and frequency of urination
iii. Weight gain and/or edema (retention of fluid)
iv. Precipitation of latent hypothyroidism or swelling and malfunction of the thyroid gland
v. Increased white blood cell count (relatively benign)
vi. EKG changes (T-wave depression and widened QRS complexes)
vii. Kidney abnormalities

c. Lithium poisoning
i. Mild lithium toxicity -- can be reversed by omitting several doses and then beginning again at lower dosage
ii. Severe lithium toxicity -- must be managed in the hospital
iii. Causes of elevated lithium level
a. Overdose
b. Sodium or fluid loss
c. Concurrent medical illnesses
iv. Early signs of lithium toxicity
a. Slurred speech
b. Drowsiness
c. Muscle weakness
d. Coarse tremor and muscle twitching
e. Loss of appetite
f. Vomiting and diarrhea
g. Ataxia (loss of muscle coordination)
h. Confusion
v. Late signs of lithium toxicity
a. Impaired consciousness (somnolence, confusion, stupor)
b. Hypertonic muscles and muscle twitching
c. Increased deep tendon reflexes
d. Hyperextension of arms and legs
e. Seizures
f. Coma
g. Death

C. Anti-depressants

1. Types

a. Tricyclic antidepressants (TCA's)
i. Dibenzocycloheptadienes
a. Elavil
b. Aventyl
c. Vivactyl

ii. Dibenzazepines
    a. Tofranil
    b. Norpramin
    c. Pertofrane
iii. Dibenzoxepines
    a. Sinequan
    b. Adapin
iv. Dibenzoxazepines
    a. Asendin
v. Dibenzo-bicyclo-octadienes
    a. Ludiomil
vi. Triazolopyridines
    a. Desyrel
vii. Prozac

b. Monoamine oxidase inhibitors (MAOI's) -- rarely used because they are less effective than TCA's, and they have particularly dangerous side effects
c. Electroconvulsive therapy (ECT)

2. Uses

a. Alleviation of depression
b. Prevention of depression
c. ECT is also useful in treating acute mania and schizophrenia

3. Side effects

a. Autonomic, primarily anticholinergic effects: dry mouth, blurred vision, and constipation; postural hypotension; urinary retention, paralysis of the intestines, and acute exacerbation of narrow-angle glaucoma are less common side effects
b. Central nervous system effects: agitation, fine tremor, angry states, mania, schizophrenic excitement, and the exacerbation of latent psychosis; sudden falls and balance problems; sedation
c. Cardiovascular effects: palpitations and depression of the heart muscle
d. Drug interactions when given in combination with certain non-psychotropic medications
e. Overdose: lethal dose of most TCA's is relatively low -- approximately 10-30 times the daily dosage
f. Side effects of ECT: common -- memory loss, headaches, muscle aches; less common -- weight gain, amenorrhea (loss of menstrual periods), increase in permeability of the blood-brain barrier, apnea (respiratory arrest), and cardiac arrhythmias

D. Anti-anxiety agents

1. Types

a. Benzodiazepines
   i. Librium
   ii. Valium
   iii. Tranxene
   iv. Azene
   v. Centrax
   vi. Verstran
   vii. Dalmane
   viii. Paxipam
   ix. Ativan
   x. Serax
   xi. Xanax
   xii. Clonopin

b. The glycerol derivatives
   i. Equanil
   ii. Miltown
   iii. Solacen
   iv. Tybatran

2. Uses

a. To treat acute situational anxiety
b. To treat phobic disorders and panic attacks
c. To treat dysthymic disorder
d. To alleviate drug withdrawal syndromes
e. To treat organic brain syndromes
f. To dispel extrapyramidal side effects
g. Used for sedation
h. To stimulate anticonvulsant activity
i. Used as a muscle relaxant

3. Side effects (if taken over long-term)

a. Tolerance of drug develops over long periods, inducing people to take more to get desired results
b. Psychological dependency
c. Physical addiction

E. Anti-side effect medication (mainly for treatment of extrapyramidal side effects)

1. Types

a. Benadryl
b. Cogentin
c. Artane
d. Ativan

2. Uses

   a. To relief acute dystonias
   b. To combat Parkinsonian-like symptoms
   c. To treat akathesia and akinesia

3. Side effects

   a. Some people experience a "high" from Cogentin and Artane

   b. Some abuse these drugs when side effects are no longer present

Medication Monitoring

Many of your clients' delusions can be confronted and alleviated with psychotropic medication. A large percentage of persons with severe mental illness will respond to psychotropic medication by becoming less delusional and experiencing fewer hallucinations. If a client's delusions and hallucinations are under control, and he or she is no longer actively psychotic, it will be easier for the client to begin to deal with both concrete (housing, eating, cleaning, etc.) and "deeper" issues. Therefore, medication monitoring is a very important part of your job as an assertive outreach worker.

There are many methods for encouraging medication compliance. First of all, you can encourage open discussions about medication, thus removing the stigma normally attached to taking medication for mental illness. Second, you can routinely question the client regarding his or her methods of taking medication in order to ensure that it is being taken correctly (especially in cases of complicated medication combinations). The third method of encouraging medication compliance, and perhaps one of the most effective, is to show clients how to use pill boxes. This means not only helping clients to arrange daily dosages of their various medications in the boxes but also periodically asking each client if you can check his or her pill box to make sure that the medication is being taken correctly. In answer to clients' frequent questions about your concern with their medication, explain that the effectiveness of medication is enhanced if it is taken daily, at the correct times. Also, emphasize to the clients your concern about their well-being and how you want them to get the maximum benefits, as well as the least amount of side effects from the medications.

As you commit to your responsibility for helping clients monitor their medications, it will also be important to answer honestly all of clients' questions regarding the effects (both positive and negative) of medication. Although you should routinely accentuate the positive benefits of psychotropic medication, do not shy away from questions about negative side effects. Try to answer the client honestly and scientifically,

emphasizing that occurrences of severe side effects are rare. You also should explain that negative effects from psychotropic medications occur much less frequently if the medication is taken correctly. Side effect medication will assist in alleviating client discomfort, which may enhance compliance. Finally, discuss with the client the trade-off between side effects and full-blown psychosis.

Medication monitoring requires close and consistent communication with the prescribing psychiatrist. You should be providing information on an ongoing basis to the associated medical staff. Work with the team, your supervisor, and the medical specialist to accomplish screening for tardive dyskensia at least every six months.

When you are involved in monitoring clients' medications, there are some ethical and legal considerations to keep in mind. First and foremost, you are not a doctor and are not legally equipped to administer medication. You can remind the client to take the medication but should not become involved in actually giving the medication to him or her. In some states, clients have the right to refuse medication. You should check with your team members and supervisors on the legal regulations in your particular state.

Psychiatric Rehospitalizations

Persons with mental illness rarely have only a single psychiatric hospitalization in the course of their illness. Many mental health consumers experience multiple rehospitalizations in one year. Several of these rehospitalizations may be unnecessary, particularly if the individual is hospitalized for nonpsychiatric reasons. There are a number of nonpsychiatric reasons why persons with mental illness are rehospitalized. First, unnecessary hospitalizations may be a result of overreactions to concrete problems. Some individuals use the hospital almost reflexively, as an all-purpose resource center or as a "therapeutic station" in times of distress, instead of reserving hospitalization as a last resort.

A second unnecessary reason that individuals are rehospitalized for nonpsychiatric reason is the barrier that exists between services for individuals living in the community and services for psychiatric hospital inpatients. A great deal of departmentalization and extensive hierarchies exist between those responsible for the patient's well-being in the community and those responsible for his or her well-being in the hospital. Because of lack of understanding and difficulty communicating and cooperating, it may seem easier to have an individual hospitalized than to work out a plan to help him or her survive in the community.

One final nonpsychiatric reason for rehospitalization of persons with mental illness is control of deviant behavior. Sometimes hospital admissions occur for no other reason than to stifle the display of behavior considered peculiar or bizarre by individuals in the community. In this sense, the mental health system has become a powerful means of social control for those who deviate from the "norm."

Continued work with inpatient services becomes imperative to facilitate the smooth transition from hospital to community and to create viable linkages among various systems. Trusting relationships with community services can give consumers healthier choices when dealing with concrete problems. The beginning of understanding and cooperation begins with each of us and how we handle our posture and our roles as assertive outreach workers.

There are times when psychiatric rehospitalizations are absolutely necessary and appropriate. The following are situations where inpatient care is clearly indicated: the client is suicidal; the client is homicidal; or the client is unable to care for himself or herself. We have discussed these issues more fully in a preceding section on crisis intervention strategies.

SUBSTANCE USE DISORDERS

Overview of Symptomatology and Treatment

As your work in the assertive outreach field continues, you will encounter many individuals with mental illness who are dually-diagnosed. These individuals have problems with substance abuse (alcohol, drugs, or other substances) in addition to their mental illness. It will become imperative that you understand current terminology used in chemical dependency, symptoms, and available treatment options. Following are descriptions of the common symptoms of substance use disorders (taken from the Diagnostic and Statistical Manual of Mental Disorders --Third Edition - Revised, 1987). Once again, we have quoted from the DSM-III-R in an effort to present the diagnostic criteria as accurately as possible. Make sure to consult the Diagnostic and Statistical Manual (DSM-III-R, 1987) for further discussion of substance use disorders.

Symptomatology

An essential feature of the **Psychoactive Substance Use Disorder** is a cluster of cognitive, behavioral, and psychological symptoms that indicate the person has impaired control of substance use, and continues use despite adverse consequences. Symptoms include physiologic tolerance and withdrawal. At least three of the following nine symptoms are necessary to make diagnosis:

1. substance often taken in larger amounts over a longer period than the person intended;
2. persistent desire or one or more unsuccessful efforts to cut down or control use;
3. a great deal of time spent in activities necessary to get the substance, taking the substance, or recovering from its effects;
4. frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations or when use is physically hazardous;
5. important social, occupational, or recreational activities given up or reduced because of substance use;
6. continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance;
7. marked tolerance in order to achieve intoxication or desired effect or marked diminished effect with continued use of the same amount;

Note: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP):

8. Characteristic withdrawal symptoms;
9. Substance often taken to relieve or avoid withdrawal symptoms.

Symptoms of the disorder should have persisted for at least one month or have occurred repeatedly over a longer period of time (DSM-III-R, 1987).

Assessment

In order to intervene, one must first assess the extent of substance use. Following is a guide to help you determine whether an individual is in the early, middle, or late stage of alcohol or drug dependence (adapted from Northeastern Illinois University, Partners in Prevention, 1987).

1. Early stage

   a. Is the client uncomfortable in situations where no drinking or drugs are involved?
   b. Is the client lying about drinking or using substances?
   c. Is the client drinking or using to "calm nerves?"
   d. Is the client having occasional memory lapses after heavy drinking or using?
   e. Does the client appear preoccupied with alcohol or drugs -- is he or she already thinking about the next drink or drug?
   f. Is the client showing an increase in alcohol or drug tolerance?

2. Middle stage

   a. Is the client rationalizing, hiding, or sneaking his or her drug and alcohol use?
   b. Is the client appearing to feel at all guilty about using?
   c. Does the client exhibit irritability when drinking or using is discussed?
   d. Is the client being dishonest in non-drinking or non-using activities?
   e. Is the client experiencing tremors and taking early morning drinks or drugs?
   f. Is the client experiencing increased memory blackouts?
   g. Are his or her promises and resolutions failing repeatedly?
   h. Is the client neglecting food?

3. Late stage

   a. Does the client appear to be experiencing a physical and moral deterioration?
   b. Does the client have unreasonable resentments?
   c. Does there appear to be a loss of "will power" and a lengthening of drunken episodes or highs?
   d. Is the client experiencing persistent remorse?
   e. Is the client's thinking impaired and is he or she experiencing severe memory loss?
   f. Does the client seem to be experiencing undefinable fears?
   g. Is the client's tolerance for alcohol or drugs decreasing?
   h. Has the client been hospitalized for alcohol or drug related incidents?
   i. Has the client reached the point of complete abandonment -- not caring about anything?

After assessing the nature of a client's substance use disorder, you will be better prepared to decide the type of intervention needed and can thus proceed with assisting the client in dealing with his or her addiction. There are numerous assessment scales available to assist you in your work, including the CAGE (Ewing, 1984), MAST (Selzer, 1971) and the Monthly Follow-Back Time-Line (Sobell et al., 1980).

Treatment

There are a number of different treatment alternatives for persons with substance abuse problems who would like to overcome their addictions. Alcoholics Anonymous (AA) is the most widely used treatment program. This model also is referred to as the "12-step program" because of the twelve basic tenets upon which the relinquishment of substance abuse with assistance from AA is based. It is run as a support group, attended by persons with

former substance abuse problems, and there are daily meetings of the group all over the country. The one difficulty with Alcoholics Anonymous is that their credo firmly prohibits individuals from taking any type of drugs; hence, persons with mental illness who are also substance abusers might encounter resistance when they admit that they are taking prescribed psychotropic medication. However, for individuals who feel uncomfortable with AA because of the group's renouncement of all medications, there is also a group that exists solely for persons who are dually-diagnosed, which is more sensitive to the problems encountered by persons with mental illness who are substance abusers. This is a program named DDA for Dually-Diagnosed Anonymous. Please check your resource file for local organizations which specialize in the service needs of this population.

Detoxification centers are a second treatment alternative for persons with mental illness who have alcohol or drug dependency. However, there may be a waiting list to get into these centers and not all of them honor a Medicaid card. Also, in many cases, a client must be drunk or under the influence of other substances at the time of intake in order to be accepted into the program. These centers range from programs where clients can go merely to "dry out" to centers where clients stay for 30 to 60 days and are involved in extensive therapy groups.

Chemical treatment of alcoholism is a third treatment alternative. This is a behavior modification treatment where an individual is on daily doses of a prescribed medication (usually Antabuse) which interacts negatively with alcohol, causing the person to vomit excessively upon drinking any amount of alcohol. This treatment is thought to be effective because it causes the individual to make the negative association between alcohol and violent nausea. It is important to note that incorrect usage of Antabuse can be lethal; therefore, make it a point to know whether or not your clients have been prescribed this medication and monitor carefully their physical reactions.

Finally, individual therapy sometimes is used in conjunction with any of the above treatment alternatives. In individual therapy, a client can begin to delve more deeply into the reasons why he or she has turned to substances. In this type of treatment, a person works to understand and resolve the issues that have led to his or her substance abuse in the past, thereby helping to prevent him or her from abusing in the future.

In addition to learning how to assess and intervene with persons who are chemically dependent, it will be useful for you to learn about many other issues confronting persons with mental illness who have substance abuse problems. First of all, there is a theory that one of the reasons persons with mental illness turn to regulated substances is that they are making an attempt to **self-medicate**. Following this reasoning, an inability to tolerate the pain that stems from experiencing upsetting feelings

causes many people to use substances in an attempt to suppress negative feelings. Persons with mental illness may abuse substances in order to try to dull the pain of the confusion and loneliness that they are experiencing as a result of their illness. These individuals also may self-medicate to try to get rid of, or at least to lessen, the intensity of anxiety-provoking delusions and hallucinations.

Because persons with mental illness do, in most cases, take psychotropic medications, **drug interaction** between prescribed medication and alcohol or street drugs becomes truly problematic. Drug interaction occurs when one drug present in the body alters the effects or action of another drug concurrently in the person's system. Interactions can take several possible forms depending on the individual's body metabolism, including: 1) drugs taken together act independently of each other; 2) drugs taken together have an additive effect, where the effect is equal to the addition of the separate effects of each drug; 3) drugs taken together have a synergistic effect, where the joint effect is superior to the effect of either drug alone; and 4) drugs taken together have an antagonistic effect, where the joint effect of the two drugs is less than the effect of each drug acting separately.

Alcohol, being a drug, strongly interferes with psychotropic medication and, in fact, any alcohol use is contraindicated when using psychotropic medication. First of all, alcohol is cross-tolerant to some of the psychotropic medications, so that the effect of the psychotropic medication is lessened. Second, in the acute stage of alcohol use, psychotropic medications may linger in the system and increase side effects. Finally, in the chronic stage of alcohol use, medication may metabolize too quickly and have no therapeutic effect.

Another factor of concern when working with an individual who has both mental illness and substance abuse problems is **cross addiction.** Some persons who are dually-diagnosed may be cross addicted to various substances. In other words, one may be simultaneously addicted to both alcohol and illicit drugs, such as marijuana, cocaine, amphetamines, or barbiturates. Because of a lack of money to buy alcohol or illicit drugs, abuse of toxic chemicals such as paint thinner or glue also occurs among persons who abuse substances, are homeless, and have mental illness. Finally, some individuals with mental illness who are chemically dependent also may be cross addicted to side effect medication, such as Cogentin or Artane, for the "high" that it reputedly gives.

When working with individuals who abuse substances, including those who have mental illness, you must be aware of the problem of **"enabling."** Enabling involves many subtle issues which are difficult to grasp and which trigger our personal concerns and feelings. This may include unknowingly making it possible and sometimes easier for the substance abuse problem to

continue. Our actions inadvertently may encourage or allow substance use. This could entail giving the client too much cash, so that buying alcohol or drugs is easier. It also entails not allowing the client to take responsibility for his or her addiction, including rescuing the client when drinking or drug use gets him or her into trouble. It is imperative to confront the client about his or her substance abuse problem. Do not allow yourself to "spare" the client from facing up to the problem, either by doing too much or too little or by allowing him or her to become dependent on you. This is especially true when his or her achievement of self-sufficiency is actually being hindered by the substance abuse problem. Be certain to consult with your team members and supervisor about these difficult issues as they arise. Developing and implementing a systematic treatment plan will assist you in overcoming some of the enabling issues.

Many issues surface when the assertive case management staff deal with clients about **money management issues.** In cases where your agency is a client's representative payee, and you are aware that this client has a substance abuse problem, you will have to be especially careful in distributing money to the client. The client may try to manipulate you into giving him or her extra money for drinking or buying drugs. He or she may deny having a substance abuse problem and, thus, may deny using money to purchase substances. It is important to be able to correctly assess whether or not a client is chemically dependent and, if so, how he or she is spending money. If your agency is the representative payee for a client who is addicted to alcohol or other drugs, you may hear frequent cries for "emergency" money; he or she may, at times, fabricate stories in order to get extra money for drugs or alcohol. Carefully select a time to plan a money management system with your client. Write it down in the presence of the client and give all parties who interact with the client a copy. Set up a system whereby the client's needs are provided for without giving him or her large amounts of cash. Take the client grocery shopping and bring just enough cash to cover the cost of the groceries; buy a monthly bus pass or tokens instead of giving money for transportation; and pay the rent for the client's housing directly to the landlord of the building instead of giving the client cash. If you are not the representative payee, you should discuss with your client the option of teaching him or her financial responsibility using these methods.

The process of recovery sometimes begins in the acute stabilization phase. This will involve detoxification as well as stabilization of acute psychosis. Engagement of the client in ongoing treatment is crucial for recovery. The second phase involves a more prolonged stabilization with continued abstinence and continued compliance in a psychiatric treatment regime. Clients should participate in ongoing rehabilitation, education, and support. They will begin to invest in the acceptance of health and will deal with their despair over their situation.

The risk of relapse continues. The third phase is a process of recovery to enhance and maintain sobriety. During this phase, clients will gain new skills for handling their feelings and situations and will improve their responsibility for themselves and their illness. Recovery is always ongoing, with continued work toward self-acceptance and self-actualization (Minkoff, 1989).

DUAL DIAGNOSIS

Clients who have severe and persistent mental illness and who meet DSM-III-R criteria for substance use disorders should be regarded as having the appropriate substance use diagnosis. They should not be considered to have a secondary diagnosis of substance use disorder, but two primary diagnoses, each of which has specific treatment needs (Minkoff, 1989). Never assume that treating one condition alone will result in resolution of the other.

Those who are dually-diagnosed also are especially challenging to treat. One of the difficulties in treating these persons is that they tend to fall into gaps between the mental health system and substance abuse treatment system. First of all, there are few services in either the mental health or the substance abuse fields that are equipped to deal with both problems at one time. In the substance abuse field, few programs acknowledge the symptoms of mental illness as such, nor do they recognize the need for psychotropic medications. In the mental health field, most programs tend to have rules for disengaging the client from the program if he or she continues to abuse substances. While these rules may help protect members of programs who do not abuse substances (as well as the staff of these programs), these policies present treatment obstacles for those who continue to engage in substance use.

Secondly, individuals who are dually-diagnosed occasionally encounter difficulties in securing appropriate treatment. Persons working in the mental health field generally have little knowledge about chemical dependency and vice versa. Sometimes, there is a lack of understanding and cooperation between service providers in these fields. You will need to work diligently to coordinate efforts to assist persons who need help from both systems.

Moreover, individuals who are dually-diagnosed often are challenging to treat because of the difficulty of clearly delineating symptoms and addressing needs. Persons who are dually-diagnosed often have firmly entrenched systems of denial supporting their situations. This denial is quite common and is nearly always a problem to be addressed. It is extremely difficult to deal with cases in which individuals have combined two denial systems: one for mental illness and another for substance abuse. It is necessary to convince these individuals

to participate actively in their own treatment. Refer to the sections on assessment and treatment of both mental illness and substance use disorders as you develop your treatment plan.

It is important to recognize that the mental health field and the substance abuse field are moving in the direction of greater understanding and cooperation. Many dually-funded programs now exist and their numbers continue to grow. Please consult with your supervisor and team members in order to be aware of these programs and add them to your resource file.

UNIT 5

Establishing Financial Security: Introduction to Public Entitlements

The Importance of Entitlements

One of the most important services that you will perform as an assertive outreach worker is helping clients obtain benefits. Social Security and Public Aid are extremely difficult systems for clients to negotiate without assistance. You will encounter many individuals who never have received the benefits to which they are entitled, or who allowed their entitlements to lapse because they were unsure of how to be reconsidered for eligibility, or who were unable to follow the necessary procedures to be reinstated. By assisting clients in obtaining benefits you will be helping to improve greatly the quality of their lives. This is because, when clients begin to receive benefits, they are on their way to situations of independence in that they are able to afford their own housing, buy their own food, and, through Medicaid or Medicare, see to their own medical care.

Overview of Entitlements (adapted from The Self-Advocacy Series, Protection & Advocacy, Inc., January, 1989)

This next section will describe in detail the eligibility criteria, amounts of money available, and any additional requirements for various types of Social Security and Public Assistance. It is important to keep in mind, however, that there is a great deal of variability in benefits from state to state. Therefore, familiarize yourself with the application requirements and monetary awards available within the state in which you are practicing assertive outreach.

Social Security -- eligibility criteria, amounts available, and additional requirements:

A. **Supplemental Security Income (SSI)**

1. Eligibility criteria

   a. Must be disabled (mentally or physically), or over 65 years of age;
   b. Available to persons who have never worked, or whose disabilities prevent them from presently working, regardless of any previous work history;
   c. Must have little or no income and few resources;
   d. Disability must prevent person from working and must be expected to last at least 12 months, or to result in death;
   e. Eligible persons must be able to present medical evidence from physician and others which shows the severity of the condition and to what extent it impedes ability to work; and

f. Persons are not eligible if found capable of any kind of employment.

2. Amounts available

a. Single person: example -- $407/month in Illinois in 1991
b. Married couple: example -- $610/month in Illinois in 1991
c. Amount available is affected by any monthly income

3. Additional requirements

a. Must be a U.S. citizen or a non-citizen lawfully admitted to the U.S. and approved for residency;
b. Must live in the U.S. or Northern Mariana Islands;
c. Must accept vocational rehabilitation services, if offered;
d. Sponsored alien: eligibility and amount will depend on his or her own and his or her sponsor's income and assets for three years after being admitted to the U.S. (with a few exceptions);
e. Substance abuser: eligibility is contingent upon accepting available treatment and receiving payments through a representative payee.

B. **Social Security Disability Insurance (SSDI)**

1. Eligibility criteria

a. Must be an eligible worker under age 65 who has lost income due to a disability and is unable to return to work;
b. Available only to persons who have paid into the Social Security system by working a required period of time (at least 5 of the last 10 years) in an occupation covered by Social Security;
c. Disability must prevent person from working and must be expected to last at least 12 months, or to result in death;
d. Eligible persons must be able to present medical evidence from physician and others which shows the severity of the condition and to what extent it impedes ability to work;
e. The spouse and children of a disabled worker may also qualify for benefits;
f. Individual not eligible if Social Security finds him or her capable of any kind of employment.

2. Amounts available
a. Varies according to work credit accumulated (number of years the disabled worker paid into the system, his or her earnings, and his or her age upon becoming disabled);

b. Affected by certain other types of government payments or by monthly income.

3. Additional Requirements

a. Must accept vocational rehabilitation services, if offered

C. **Medicare** -- two parts (hospital and medical insurance)

1. Eligibility criteria

a. Hospital insurance:
i. Any person age 65 or over, who is entitled to monthly Social Security or railroad retirement benefits, or
ii. Has worked long enough to be insured under Social Security or the railroad retirement system, or
iii. Would be entitled to monthly Social Security benefits based on spouse's work record, or
iv. Has worked long enough in Federal, State, or local government employment to qualify for Medicare, or
v. Any person under age 65 who has been entitled to Social Security disability for 24 months, or
vi. Has worked long enough in government employment and meets the requirements of the Social Security disability program, or
vii. Any person of any age who has permanent kidney failure and needs maintenance dialysis or a kidney transplant, and who is insured or is getting monthly benefits under Social Security or the railroad retirement system, or
viii. Has worked long enough in government employment

b. Medical insurance:
i. Almost anyone who is 65 or older, or
ii. Almost anyone who is eligible for Medicare hospital insurance
iii. Social Security or government work credits unnecessary

2. Amounts available/coverage

a. Hospital Insurance:
i. All covered services for inpatient hospital care for the first 60 days, except for the first $592
ii. All covered services for skilled nursing facility care for the first 20 days, and all but $74 a day for up to 80 more days

iii. Unlimited number of home health visits from a participating home health agency, if person is confined to home and meets certain other requirements
iv. Hospice care for terminally ill beneficiaries by a Medicare-certified hospice, for a maximum of two 90-day periods and one 30-day period

b. Medical Insurance:
i. Monthly premium of $28.60 in 1990, directly deducted from your check
ii. 80% of approved charges for covered services, after an annual medical insurance deductible ($75 in 1990)
iii. Covered doctors' services administered anywhere in the U.S.
iv. Outpatient hospital services for diagnosis and treatment, such as those administered in an emergency room or outpatient clinic of a hospital
v. Unlimited number of home health visits, if required conditions are met and person does not have Medicare hospital insurance
vi. Other medical and health services, such as ambulance transportation, home dialysis equipment and services, independent lab tests, outpatient physical and speech pathology services, and X-rays and radiation treatments

Public Assistance -- eligibility criteria, amounts available, and additional requirements:

A. General Assistance

1. Eligibility criteria

a. Single persons (over age 18) with no dependents, who are neither aged, blind, nor disabled
b. Long-time unemployed or never employed persons

2. Amounts available

a. Flat grant (example: $165/month in Illinois in 1991), regardless of living situation (homeless, housed alone, with roommates, etc.)
b. Supplemented by a food stamp allowance (amount determined based on individual's living situation)
c. Also supplemented by an 07 medical card, which allows only limited medical care

3. Additional requirements

a. Applicants are required to participate in "Project Chance" (educational and employment training

program) unless they have "good cause" not to participate (homelessness and mental illness are among the criteria for exemption);

b. If not found exempt from Project Chance, a physical examination is required.

B. **Aid to Families with Dependent Children (AFDC)**

1. Eligibility criteria

a. Mothers and/or fathers with one or more children in their care
b. Pregnant women in their last four months of pregnancy

2. Amounts available

a. Cash grant, which increases with each additional child in mother's and/or father's care (example: $268/month for a mother with one child in Illinois in 1991)
b. Supplemented by a food stamp allowance which increases with each additional child (amount determined based on family's living situation)
c. Also supplemented by an 04 medical card

3. Additional requirements

a. Some parents may be required to participate in Project Chance;
b. If required to participate in Project Chance, a physical examination may also be required.

C. **Aid to the Aged, Blind, and Disabled (AABD)** -- State Supplemental Payment

1. Eligibility criteria

a. Interim assistance (P-3):
   i. Persons who are aged, blind, or disabled and who have an active claim for SSI with Social Security but have not yet been notified of their eligibility
   ii. Single persons living alone

b. "Restaurant Allowance":
   i. Single persons living alone who are defined by Social Security as aged, blind, or disabled and whose income through SSI is insufficient to meet their basic maintenance needs
   ii. Persons whose place of residence has no cooking facilities

2. Amounts available

a. Interim assistance (P-3):
   i. Cash grant (example: $165/month in Illinois in 1991)
   ii. Supplemented by food stamps (among determined based on individual's living situation)
   iii. Also supplemented by a P-3 medical card, which covers most medications and health care

b. "Restaurant Allowance":
   i. Varies from person to person, but an average of approximately $100/month in Illinois in 1991
   ii. Supplemented by an average of approximately $15/month in food stamps in Illinois in 1991
   iii. Also supplemented by an 03 medical card

3. Additional requirements

a. Interim assistance (P-3):
   i. Must be a U.S. citizen by birth or naturalization, or an alien who has been legally admitted for permanent residence;
   ii. Applicant must be a resident of the state in which he/she is applying for AABD;
   iii. Must agree to repay Interim Assistance upon being approved for SSI.

b. "Restaurant Allowance":
   i. Must be a U.S. citizen by birth or naturalization, or an alien who has been legally admitted for permanent residence;
   ii. Applicant must be a resident of the state in which he/she is applying for AABD.

D. **Medicaid**

1. Eligibility criteria

a. Automatically eligible if qualified to receive a cash payment or food stamps through General Assistance, AFDC, or AABD programs
b. May be eligible if needing assistance only with medical expenses although receiving no cash grants or food stamps

2. Amounts available/coverage

a. Almost all in- and out-patient services, lab and X-ray services, home nursing care, skilled nursing facility care, psychiatric services, physician's services in clinic or office, rehab. services, dental and eye care, medical supplies, medications, etc.

b. Funeral and burial expenses:
   i. If deceased was eligible for medical services at time of death;
   ii. If there is not enough money in deceased person's estate to pay the cost of funeral and burial;
   iii. If there is no legally responsible relative to pay the costs; and
   iv. If application is made within five days of death.

3. Additional requirements

   a. Applicant must apply for Medicaid in the county in which he or she lives;
   b. Applicant must be a U.S. citizen or have legal alien status;
   c. Applicant must report all income, resources, third party insurance, etc. which have a bearing on eligibility.

Other Financial Resources

Your clients may be eligible for other financial resources in lieu of, or in addition to, Social Security and Public Assistance. There are a number of different sources from which to receive benefits, and these will give cash awards which are at least equal to, if not greater than, the combination of Social Security and Public Assistance. First of all, if clients, or their spouses or parents, have served in any branch of the U.S. Armed Forces, they may be eligible for **Veterans' benefits**. If a client believes that he or she may be entitled to receive these benefits, contact the local Veterans' Administration office to determine whether the client is indeed eligible and, if so, how to apply.

Second, if a client, or his or her spouse or parent, has ever spent a significant amount of time working for the railroad, he or she may be eligible for **railroad benefits**. To further explore this possibility, call the railroad where the client was employed to see whether he or she is entitled to receive benefits, and how to apply. Third, if any of your clients, or their spouses or parents, have worked for government agencies, they may be entitled to a **government pension**. In order to ascertain whether a client was employed in a government agency for enough time to be eligible for a pension, contact the main branch of that specific agency, and find out how to apply.

Worker's compensation is another financial resource for which clients may be eligible. If a client tells you that he or she was physically injured on a job and that a claim was filed at the time of the injury, call the company where the client was employed to determine whether he or she is eligible to receive worker's compensation and, if so, how to apply. Finally, your clients may be eligible for **social service grant money**. Your own agency, or another social service agency with which you are

familiar, may have emergency grant money which can be made available to clients who are homeless and whose benefits are pending. Find out if this is the case and what steps must be taken in order to obtain a temporary loan for clients so that they may be housed while waiting for their benefits to be approved.

Applying for Entitlements

Applying for entitlements is generally a complicated process, and, in most cases, clients will need your assistance in order to facilitate the application process. When helping clients to file applications for Social Security or Public Assistance benefits you must find out the correct catchment zone in which the application is to be filed. To accomplish this, call the local office and ask where the client should file the application, based on his or her address. It may be possible to set up an interview with the Social Security or Public Aid offices ahead of time, so make sure to call before taking the client in to file an application; if not, you will have to go to the office with the client and be seen on a first-come, first-served basis. Finally, it is now possible to file a claim for any type of Social Security benefits over the telephone; you may find the "1-800" number in your local phone book.

In order for clients to be prepared fully for an initial interview at either Social Security or Public Assistance, there are a number of documents that should be gathered ahead of time. The following list of important documents will facilitate the application process; therefore, help your client gather them **before** the interview:

1. A copy of the client's birth certificate or other proof of age;
2. The client's Social Security card or number;
3. The client's medical and treatment records (especially for application to Social Security);
4. Any work records that the client may have;
5. The client's apartment lease and/or landlord's name, address, and telephone number, if the client is not currently homeless;
6. The cost of the client's utilities, if currently housed;
7. The cost of the client's monthly food bills, if he or she is housed and has cooking facilities; and
8. Information about any income or assets (bank records, etc.).

It is important that you help clients prepare for their interviews by supporting and strengthening their cases, especially when they are applying for Social Security benefits, which can be a particularly complicated process. In contrast to most other interviews, an interview for benefits is one in which it is to the client's advantage not to look too high-functioning. Before taking a client through the application process, empathically counsel him or her about why it is necessary to

stress the negatives of his or her life situation. The following is a list of ways in which you can do this:

1. Prepare a list of all job duties that the client was able to perform in the past;
2. Prepare a list of all the activities that the client is no longer able to do;
3. Prepare a list of all other changes that the client has experienced since the onset of his or her disability;
4. Prepare a list of all medications that the client is currently taking;
5. Prepare a list of all social services and non-medical treatment that the client is currently receiving or has received in the past;
6. If the client is currently working in a sheltered workshop, bring his or her work history and other reports from workshop;
7. If the client left a job for medical or disability-related reasons, get a letter from former employer(s) stating how the client's disability related to discharge from the job;
8. Prepare a list of all of the problems that the client is experiencing with daily living tasks and of any tasks with which he or she needs special assistance;
9. Have the client's psychiatrist and/or therapist prepare a letter in advance, to be brought to the initial interview, that specifically details how the client's condition is impairing his or her ability to work and perform daily activities.

As much as possible, when preparing documents for a client's application for benefits, use behavioral language; in other words, concretely explain exactly what it is that the client can and cannot do. It is best to avoid emphasizing diagnostic categories or psychological theories.

Working with Government Agencies

Because you will be acting as an advocate on behalf of clients when you take them through the entitlements application process, it is imperative for you to **stay informed of any policy** specifically affecting Social Security or Public Aid benefits. There are two important ways to keep up with any recent policy changes: be aware of all activity regarding disability-related bills in the state legislature; and periodically call your local Social Security and Public Assistance offices to double-check on any policies about which you might have questions or that you've heard might be in transition.

When you work closely with government agencies such as Social Security and Public Assistance on a consistent basis, it becomes necessary to learn methods of **"speeding up" the bureaucracy.** This includes becoming an expert on Social Security and Public Assistance rules, regulations, and policies, so that you can help the client move through the systems more quickly.

Another important way to eliminate part of the bureaucratic process is to make contacts with workers at the local Social Security and Public Assistance offices. Make an attempt to discover which government employees tend to go less "by the book;" these individuals usually have the clients' best interests at heart and will try hard to facilitate the application process for your client.

Money Management

Most social service agencies working with homeless persons with mental illness have an option of becoming the **designated representative payee** for clients who receive Social Security benefits. Being a client's representative payee entails receiving a monthly check for him or her in the agency's name, which must then be disbursed in a responsible manner. This service is usually reserved for individuals who have trouble with, or are absolutely incapable of, money management. However, when accepting the responsibility of representative payeeship for a client, there are some legal ramifications to bear in mind: 1) the benefits must be used solely for the client's expenses and welfare; 2) your agency must be able to document how the client's money is being spent; and 3) your agency must report to Social Security any information that might affect the amount of benefits payable to the client. Call your local Social Security office to determine whether the procedures given below are accurate in your particular state.

The procedure for applying to become a client's representative payee is quite simple. If the client consents to having a payee and is not yet receiving benefits, it is best to notify Social Security of your agency's intent at the time of initial application. However, if the client currently is receiving benefits when he or she decides to designate your agency as representative payee, you must file an application for this before the 10th of the month in order for the client's next SSI check to be made out in your agency's name. If the client will not consent to having a representative payee but you feel that one is necessary due to poor money management, you must get the client's psychiatrist to document the behaviors that prevent the client from managing his or her own money.

Once your agency becomes a client's representative payee, you will need to **set up a budget** with him or her in order to account for the entire monthly Social Security check. Figure out with the client exactly how much money he or she will need for monthly rent, food, transportation (bus pass or tokens), personal hygiene products, cleaning supplies for his or her room, and other personal items (e.g., cigarettes or coffee in a restaurant). Once you and the client have agreed upon exact amounts for all of the above, write down the budget, give a copy to the client, and keep one for agency files.

After devising a budget, you and your client should come to an agreement about a **money disbursement schedule** that will sufficiently satisfy the client's budgetary needs. Set strict

limits with the client regarding how often money will be disbursed and how much he or she will receive at one time. When a client begins to show greater responsibility in handling money, gradually taper off the disbursement schedule; in other words, proceed from money drop-offs that occur more than once a week, to weekly drop-offs, to bi-weekly drop-offs, and finally, to monthly drop-offs, if possible. Your goal will be to encourage the client to become fully independent in regards to money management as quickly as possible.

When your agency takes on representative payeeship responsibilities, often you will have to handle **requests from clients for additional money**, exceeding the budget that their monthly incomes prescribe. When such a situation occurs, remind the client of the disbursement schedule that the two of you created together and agreed to follow. If, after a gentle reminder, the client continues to ask for money that exceeds his or her monthly budget, point out that he or she is living with a limited amount of money that must be stretched to last throughout an entire month. Try to boost the client's willpower to make money last. Also, it is important that you learn to discern when clients' demands constitute a real need for emergency cash.

Finally, always remember the following **rights of clients in regards to representative payeeship**: 1) clients have the right to request that another agency or person take over responsibilities of representative payeeship if they object to the way the money is being handled or suspect that their money is being misused; 2) clients have the right to request that Social Security give them full control over their own benefits; and 3) clients have the right to request documentation from representative payees illustrating such things as how their money is being disbursed or how much money has been put into savings. Make sure to call your local Social Security office to ascertain whether this is a complete list of client rights. Because of these important client rights, representative payees must be dedicated to clear and accurate record-keeping, detailing exactly how clients' money is disbursed.

UNIT 6

Establishing a Therapeutic Alliance: Relating to the Client in His or Her Setting

Relating to a Person with a Severe and Persistent Mental Illness

You may or may not have had prior experience relating to persons with long-term mental illness. Perhaps you have worked in the mental health field before your current job, or you may have a friend or family member with a severe and persistent mental illness. If so, you already realize that relating to individuals with this disability can be somewhat different from relating to others in your life. Particularly when they are in psychotic states, persons with mental illness may think, feel, and reason in ways that seem foreign to you. Hence, there are a number of techniques to use and questions to ask yourself that will guide you in building relationships with clients who have long-term mental illness.

First, train yourself to be a **expert observer** in your work with clients. Continually assess how the client is acting.

1) Does he or she seem to be psychotic at the present time?
2) In what ways are the client's actions similar to those of persons who do not have mental illness?
3) In what ways do the client's actions set him or her apart?

Second, employ **active listening** techniques when you are relating to clients. This entails paying attention at all times to what the client is saying, even if the content of his or her discussion is delusional. There may be times when a client's delusional thoughts give you a clue to understanding his or her feelings at that particular time. Also, give the client clear indications that you are listening attentively. This may include the following: nodding; asking for further clarification of what the client is saying; and responding in such a way that the client knows you are listening (i.e., using expressions such as, "I understand what you mean," or "I hear what you are saying").

Third, do not be afraid to **ask the client questions**. If you would like to find out more about a client, ask him or her in a straightforward manner; you can take an active interest without intrusive probing. It is important to show clients that what they have to say is valuable and that you would like to hear more from them so that you can get to know them better. Also, instead of ignoring clients' delusions, you can use gentle questioning to

try to get behind the delusions in order to find out more about your clients' thoughts and feelings.

A fourth technique that is especially important when working with persons who have severe and persistent mental illness is to openly **display your empathy** for them. As you continue to work with this group of people, you will better understand the painful experiences that individuals with mental illness often go through during the course of their illness. Showing empathy means being able to express to clients that you feel for them and for what they have been through.

Another useful technique to employ when attempting to relate to persons with long-term mental illness is to help them **give a name to the feelings** that they are experiencing. Sometimes individuals with mental illness have a difficult time expressing emotions or believe that you can in no way understand their feelings. Therefore, by identifying emotions that you sense in clients, you will be helping them to get in touch with hidden feelings and showing them that you are trying to understand them better. Essentially, this process entails being sensitive to the emotions that a client is displaying, clearly identifying these emotions in your mind, describing them aloud to the client, and then asking the client for verification. You can get verification about the feelings that you sense in a client by either asking questions or by directly stating what you think the emotions are. For instance, approach the client with expressions such as "You look like you are in a good mood today," or "Are you sad today? It seems like something is bothering you." Giving a name to clients' inner feelings opens up avenues for deeper discussions.

A sixth method that you can use to facilitate your relationships with clients is to help them stay focused on **here-and-now situations**, when appropriate and possible. By using persistent efforts to assist clients in concentrating on the present, you will not only be helping them to develop better conversational skills, but you also will be better able to assist them in meeting their daily needs.

Finally, an essential ingredient in any helping relationship, but particularly in relationships with persons who have mental illness, is **building trust**. Building trust means going at the client's own pace (i.e., not trying to rush him or her into getting to know you more quickly than is comfortable). This also means continually demonstrating to clients that you will be there for them, despite their repeated attempts to test the limits of your relationship with them. One final point which is imperative to building trust with individuals who have mental illness is to follow through when you tell them that you are going to do something for them. Although you may be inclined to tell clients that you will complete impossible tasks for them, out of a need to appease them or to win their approval, making

empty promises to clients is an immediate way to shatter their trust. Never make a promise to a client that you cannot keep.

Safety

Safety is another issue to keep in mind when relating to clients in their environment. Situations may arise where you will need to evaluate whether or not your safety is in jeopardy. If such a situation occurs, there are many safeguards to take in order to ensure your well-being.

The first safety guideline to remember when working with your clients, particularly those whom you believe have the potential to be dangerous, is to **read non-verbal cues regarding personal space**. Try to become adept at noting clients' agitated body movements, signs of impatience, or any other clues to their need for space. These observations about clients' non-verbal cues should be voiced aloud to them. In that way, you can receive verbal confirmation from clients when you sense that they feel as if you are infringing on their space. Also, learn to sense when a client might feel hostile about the help that you give. There will be days when clients simply do not want you around; respect their wishes.

A second way to ensure your safety with clients is to attend to any subjective sense of being unsafe and to share this feeling with the rest of your assertive outreach team. Trust your instincts; if you are feeling unsafe with a client, you probably are unsafe. Therefore, bring your observations about the way a client makes you feel to the team so that a plan can be made for future visits to the client. Perhaps someone else should see this client for a while, or he or she could be seen by a pair of assertive outreach workers. It will be important for you to remain a part of the treatment team with the individual.

Another good rule of thumb to follow when relating to clients in their own environment is to **avoid having your means of exit blocked**. This way, if you determine that a client is angry or agitated, you will be able to exit the room quickly if the need arises. Avoid blocking the client's means of exit. If the client feels a need to leave the room to keep calm, you will want to honor his or her position. Also, whenever in doubt about your safety with a client, make arrangements to meet with him or her in a public place that is mutually acceptable.

A fourth strategy to use to guarantee your safety with clients is to always **make sure other team members know where you are when you are doing outreach in the community**. Do not make a visit to a client unless team members know where you are going and approximately what time you expect to return. If you decide to change your day's itinerary and do an unplanned visit to a client, call the office to tell someone of your whereabouts.

Finally, employ the **"buddy system"** when you are visiting a client who is actively psychotic. This is helpful for a few different reasons: you may need the emotional support of another team member if the visit becomes extremely stressful; and you should have at least one other assertive outreach worker with you if there is a chance that control of the situation becomes problematic.

UNIT 7

The Total Treatment Approach: Team Issues and Activities

Introduction to the Team Concept

There are many different ways in which assertive outreach can be performed. One of the ways that assertive outreach differs in execution from agency to agency is in the approach to caseload management. In the individual approach, workers are assigned clients with whom they work **exclusively**, so that each assertive outreach worker has his or her own caseload. Other agencies may employ a team approach, whereby all assertive outreach workers act **together** in decision-making and share responsibilities toward all clients served by the agency.

If one were to operationalize the "ideal" assertive outreach team, a number of different characteristics would be apparent. First of all, when employing a team approach **no individual worker carries his or her own caseload.** Instead, each case manager has working knowledge of each client served by the team or agency. Preferably, clients are seen by staff on a rotating basis, so that each client is relatively familiar with each staff member, and vice versa. The ultimate goal of this rotation is for each client to feel fairly comfortable with each worker.

An operationalization of the "ideal" team would also involve a **low ratio of clients to workers.** Ideally, the ratio of clients to workers should be no more than 10:1 and, if the needs of clients are particularly great, an even smaller ratio should be utilized. Keeping a relatively low ratio helps to ensure maximum effectiveness. It is almost impossible to help clients meet difficult needs if team workers are stretched beyond their capabilities by having to serve enormous numbers of clients.

Another crucial characteristic of an assertive outreach team is a **strong communication network among team members.** Daily meetings are imperative, during which all workers share information about their day's visits with clients. These discussions allow all workers to be equally familiar with clients' cases, so that one worker can pick up with a client where another worker left off the day before.

Finally, **treatment plans** for each client should be **reviewed by the entire team** on a weekly basis or, if necessary (e.g., if a client is in crisis), more frequently. In this way, the team as a whole can make decisions about whether or not the client's treatment plan is appropriate, whether his or her needs are being met in a timely fashion, or whether a new plan is necessary.

Utilizing a team approach can be advantageous for both client and worker. One of the most basic advantages of the team approach for your clients is that, because the team approach dictates that all workers be familiar with all clients, workers can subsequently be deployed with **maximum efficiency when several clients are in crisis** simultaneously.

A second advantage of the team approach for the clients served by the agency is that this method is **not disruptive for clients** when team members are sick or take vacations. During such times, other team members merely fill in the gaps left by the absent worker. Because clients are accustomed to working with several different staff members, the absence of one worker often goes unnoticed.

A third advantage to using a team approach to serving clients is that there is **less likelihood of negative transference experiences** and, when such problems do arise, they are generally easier to resolve. If transference between a client and worker does occur, the worker can simply be eliminated from the rotation for that client for a short period of time, until the situation dissipates. Just as the team approach minimizes the possibility of negative transference experiences for clients, it also makes negative countertransference experiences for workers less likely. Transference and countertransference issues are extremely difficult to process and understand. This is a time when your co-workers and supervisors will be particularly helpful. Listen carefully to their input and challenge yourself to explore your own issues.

Finally, an important advantage of the team approach for clients is that, by using such an approach, **clients are exposed to a healthy variety of helping personalities and ethnicities**. In theory, clients have the option of gaining something from each different team member with whom they work. The hope is that the amalgamation of various personalities and ethnicities will provide a balance for clients that will assist them in getting their needs met in an optimal fashion.

There also are a number of advantages to the team approach for the assertive outreach worker. First of all, the team approach to serving clients helps to **minimize on-the-job stress and burnout**. As an assertive outreach worker, you will encounter some difficult problems; the confrontation of these problems may require that you expend a great deal of energy. However, with the team approach the rotation system for meeting with clients is conducive to giving staff members periodic respite from the most difficult problems. Also, responsibilities are diffused throughout the team, making a difficult job a little less overwhelming.

Team Treatment Activities

There are many treatment activities that an assertive outreach team can perform together. First of all, as a team, you and your fellow outreach workers can **compile treatment histories for each client**. To compile a treatment history the assertive outreach team reviews a client's records (obtained from hospitals, rehabilitation programs, intermediate care facilities, etc.) in treatment planning sessions. From the information present in the client's records, the team will put together a detailed summary of the various treatment methods that have been tried with the client, which methods have worked, and which have not been successful. Having a treatment history such as this for each client helps the team to make decisions about the subsequent course of a client's treatment.

Treatment planning is a second activity that is performed with the entire assertive outreach team present. This type of planning requires that immediate plans regarding interventions and goals be discussed with each new client as he or she enters the agency's program. (If the client is involved with family members, they too should be included in planning, with the client's consent.) During intake and the first few meetings with a new client, you and your team members will get input from the client (and his or her family, if possible) about the outcomes that he or she hopes to obtain in partnership with the assertive outreach team.

Based on the information obtained from the client, you and your team will write out a detailed treatment plan during the team treatment planning session. This plan will be kept on file and used as a guideline to be referred to in work with the client. It is imperative that information (i.e., goals and interventions for the client) be realistic and attainable.

Treatment plan review sessions are a third team treatment activity. These sessions should be held on a <u>weekly</u> basis, and when one or more clients are in crisis, treatment plan reviews should be held more often. The purpose of treatment plan review sessions is threefold. First, these sessions should be used to evaluate clients' progress. By reviewing clients' treatment plans your team will be able to see how far clients have come. The original treatment plan serves as a baseline measure which can be updated when clients' goals are reached. Periodic reviews allow the team to assess whether or not the current treatment plan is moving the client in a positive direction. If progress seems to be stagnating, the client and assertive outreach team will have evidence showing that the treatment plan needs revision.

A second purpose for team treatment plan review sessions is to encourage your team to feel free to make innovative changes in

these plans. The original treatment plan should not be viewed as something set in stone. Instead, the team should continually review and revise it in order to come up with a plan that works well for the client.

Finally, treatment plan reviews are useful in helping your team to acknowledge its impact. Treatment plan reviews can serve as positive reinforcers for the team and clients, illustrating to all that some progress, even if it be minor, has been made. Updating progress in treatment plan reviews provides a concrete reminder to your team of the good work that is being accomplished.

Team Building Activities

In order to serve clients most effectively and efficiently, it is imperative that all team members be able to work well together. Hence, activities must be emphasized within your agency that promote good teamwork. There are a number of team building activities that the agency can utilize both within and outside of the agency that will help to strengthen your team. One of the first activities that can be used both for team building and as a means of relaying information is the **inservice training**. During an inservice training, an individual either from within or outside of the agency imparts information to the team that will be useful in work with clients. In this type of setting, team members are becoming trained as a team by learning new things together. Examples of topics to cover might include: medications, AIDS/HIV infection, entitlements, communication, listening skills, and substance abuse disorders.

Another important team building activity is to hold **open discussion sessions** on a regular basis. These sessions give team members an opportunity to discuss team problems and to work out personal differences. Using an impartial individual -- in many cases the team supervisor -- as a facilitator, team members can be helped to get along better and all workers can brainstorm about ways to help the team run more smoothly.

Potlucks are a third team building activity that can take place within the agency. Potlucks offer a way of planning fun afternoon breaks together, and their emphasis on sharing, with everyone contributing to the party, can help individuals work better as a team.

An occasional day long retreat, strictly devoted to team building, can be useful. There are a variety of activities and topics that could enhance both knowledge and interpersonal relationships for staff. Several nationally and locally recognized consultants are available to come to your setting. Arrangements can be made privately or through some professional organizations. Costs vary but usually can be negotiated. This

break from the routine allows everyone the chance to step back and re-group with greater commitment and enthusiasm.

Finally, **cultural issues** should always be attended to when attempting to build your team into a cohesive whole. Ideally, many cultural groups will be represented on your team. Hiring assertive outreach workers from different backgrounds will be beneficial to team members as they will then be presented with the opportunity to learn about the different customs indigenous to each culture. Moreover, clients will gain quite a bit if their own cultures are represented by those of staff members.

Since your team will, in all likelihood, be comprised of individuals from different cultural backgrounds, utilize these differences in team building activities. For instance, when the agency throws a potluck luncheon, ask each team member to bring a dish that is native to his or her background. Encourage all team members to discuss cultural norms and biases in planning sessions. Get outside assistance if you encounter a cultural situation in which no one has expertise.

When Something Terrible Happens -- Processing as a Team

As much as the assertive outreach team tries to improve the quality of clients' lives, there will be times when, despite a great deal of effort with a client, something terrible happens to him or her. At such times, the assertive outreach team can be a source of support for individual team members. One situation for which you and your team members should be prepared is **finding out that a client has a fatal illness** such as cancer or AIDS. Often persons with mental illness who are homeless have little contact with family or friends; hence, the assertive outreach team may be a client's sole source of support through a lingering and eventually fatal illness.

If you and your team discover that a client has a fatal illness, it will be imperative that you work at coming to terms with this **together**. Coming to terms will entail discussing as a group feelings about the client, as well as practical matters about how he or she will be cared for during the course of the illness. Your team will need to work at being able to bolster and support one another and, especially, the client throughout the illness. At such a time, extra supervision for individual team members may be necessary.

Another occurrence that becomes a possibility when doing assertive outreach is **mourning a client's death**. A client may die as a result of a fatal illness, an accident, murder, or suicide. Coming to terms with a client's suicide may be particularly difficult for the team. Because of the nature of assertive outreach and the frequent contacts between clients and the assertive outreach team, outreach workers may experience a

sense of guilt in the case of a client's suicide. It is not uncommon for team members to wonder, "Was there something more that we could have done to prevent this?" It is always important to remember that you and your team have worked together and tried to do the best that you could. Clients ultimately hold responsibility for themselves. You and your team improved the client's quality of life and were a positive force in his or her life. Try to recall accomplishments.

Anger is another common feeling that occurs when mourning a client's death from suicide. It is not unusual to feel angry at the client for "deliberately" choosing to leave behind people who love and care about him or her. It is essential to process this anger as a team, along with any other feelings provoked by the suicide. At such a time, special team sessions should be arranged in order to help all workers come to terms with particular issues surrounding the client's suicide. If the client had been in contact with family or friends at the time of his or her death, these individuals might also be invited to these sessions so that they too will have a chance to process the death of their loved one. Recognize that a discussion will not, in and of itself, end the mourning or the anger. However, after mourning a client's death, it is also important to learn to **move on as a team**. The process of mourning should not be ignored. Team members will need to be able to openly grieve with the team, instead of bottling up feelings about the experience. If feelings of sadness, guilt, and anger about the client's death are not expressed, then these feelings may interfere in work with other clients. Nevertheless, after an appropriate amount of time is spent grieving and processing a client's suicide, the team needs to be able to let go of this painful experience and devote attention to other clients.

Part of the "moving on" process should include acknowledgement of anything positive learned from the extremely negative experience. As a team, you can discuss whether or not something could be done differently if a similar situation occurs in the future. Also, you and your team members will gradually become better equipped to deal with life's tragedies.

If team members are having a particularly difficult time moving on from the client's death, outside consultants may be utilized by the agency to facilitate the grieving and adjustment processes. Individual team members may also feel the need to work through the tragedy outside of the agency in individual counseling.

UNIT 8

Establishing Community Support Linkages: Working with Collateral Service Providers

Introduction to Community Resources

Advocacy is one of the most important components of your job as an assertive outreach worker. Advocacy entails working for or on behalf of another. We often take for granted the complicated nature of surviving in a large and relatively unfriendly community; in order to do so, one must be able to assert one's needs in a consistent and forthright manner. However, sometimes persons with mental illness who are homeless lack the requisite skills or resources to negotiate the many barriers that exist in any large community. Therefore, being well equipped to advocate on behalf of clients is imperative in assertive outreach, and in order to best be able to do so, you must become an expert on community resources.

Without a good understanding of the resources in the community in which your clients live, you will be unable to help clients function maximally there. In any community, resource options can be broken down into subgroups, although overlap often exists. Some of the major subgroups of community resources include those in the mental health system (both inpatient and outpatient), housing options, medical assistance, sources of financial assistance, and vocational programs. The following will help you to make the imperative move towards understanding how these different subgroups function:

1. What must be done to help a client initially obtain these resources and to maintain them over the long-term, if necessary?
2. How are these resources represented in different areas of the community?
3. What kinds of linkages exist between resources within each subgrouping and between resources from different subgroupings?

Your agency will, in all probability, have a **resource list** that has been compiled gradually since the beginning of the agency's existence. This list should explain, in some detail, all of the different resources utilized by the agency. You will need to orient yourself to this list, familiarize yourself with its various options, and become adept at using it. Although you will certainly learn more about existing resources on the job, it is necessary to be aware of some of the options that are out there for clients ahead of time, so that if a client is in need

of a particular service, you can automatically help him or her obtain it.

There is a certain art to **utilizing the resource list.** First of all, you must learn **how the list is organized** and where different resources can be found on the list itself. If the list is a comprehensive one, it will be easy to overlook a resource simply because of a lack of familiarity with the way the list is organized. **Develop a working knowledge of different areas of the community.** Such knowledge will help you identify where the resource is located and if it is readily accessible to your clients.

The third important skill to learn as you begin to utilize the agency resource list is **how to approach the facility listed.** Depending on the level of formality dictated by the facility, you will need to vary your style of procuring the resource for your client. With some community resources, you will need to advocate for the client by phone, others by letter, and others in person. Learn the rules of the resource and use them in order to get the maximum benefit for your clients.

Finally, an important concomitant to utilizing the resource list is **marking the list.** You can make notations on the list as you learn more about the various resources. Also, you might want to put asterisks next to the resources on the list that you know are particularly amenable to accepting your clients. Finally, an essential component of advocacy involves noting those resources on the list that you and your team members have found inappropriate for your clients. You will want to discuss with your co-workers your choices about taking an active stance to change the facility or to advocate for new resources.

As part of your job as an assertive outreach worker, you have a responsibility to **investigate new community resources** and to **disseminate information about them** to other members of your team. One of the first things that you will learn in your new job is that you can never have too many resources. Keep your ears open for new possibilities, and actively research new resource options to determine whether or not they are appropriate for your clients.

When you discover a new resource, this information should be shared. You should **verbally disseminate information about new resources** during team meetings and make sure that the **resource list is updated** when new resources become available. Do not leave a resource off the list simply because it may be "informal" or not a part of the social service or mental health systems. Anything that exists in the community which could be beneficial to the clients should be considered a resource.

Initial Linkage and Referral to Collateral Service Providers

There are some basic rules to follow when making the initial referral and linkage of a client to a collateral service provider. These procedures differ slightly depending on the subgroup under which the resource falls. For instance, when linking a client to a housing resource, such as a **single-room occupancy hotel (SRO)**, it helps to have established a relationship with the owner or manager before referring the client. When your agency is on friendly terms with the owner of an SRO hotel, he or she will be more likely to accept clients from you who have more difficult problems. Also, clients usually will be treated more favorably and will be given more chances if you have established a strong link with the manager of the building. Finally, it is helpful to call the manager in advance of bringing in a client who wishes to view a room or fill out an application.

When referring a client to a **community mental health center (CMHC)** or clinic to see a counselor or psychiatrist, call the center ahead of time to set up the initial appointment for the client, identifying yourself as his or her case manager. During this initial linkage over the phone, give basic referral information regarding the client. It is helpful to accompany the client to the first appointment, both to assist the client in overcoming any anxiety that he or she might feel and to give the doctor or therapist any information about the client that would be beneficial in subsequent treatment. You may need to continue to take the client to appointments and act as a liaison.

When linking a client to any sort of **day program**, e.g., vocational or rehabilitative, call the program in order to find out the procedure for application. Ask whether the client should fill out an application before coming in for an interview and what kinds of documents or information the client needs to bring to an interview. Attend the first interview and/or the orientation with the client, if possible and appropriate.

Referral of a client to a **drop-in center or day shelter** is another type of linkage that requires some work on your part. Call the director or intake worker of the center or shelter ahead of time to say that you will be sending or bringing the client over. If you are not accompanying the client, give specific directions to get to the shelter and who to ask for. If the client feels wary about going to the drop-in center for the first time alone, accompany him or her.

Another type of linkage that you will perform in your job as an assertive outreach worker is between clients and **medical and dental services.** When referring a client for medical or dental services, you must call in advance to see if the clinic takes Medicaid or to verify the financial arrangements. Arrange an

appointment for the client on the earliest date possible, explaining if the client is in urgent need of services. When the appointment date arrives, accompany the client to the clinic in order to ensure that all runs smoothly.

Sometimes you may feel tnat a client is having a difficult time surviving in the community, despite intensive assertive outreach services. If such a case arises, you will want to attempt to link the client with an **intermediate care facility (ICF) or halfway home** or other more supportive setting. Call the facility and arrange an intake interview between the client and facility staff. Accompany the client to the interview, advocating on his or her behalf about the reasons he or she would be an appropriate candidate for these services. If it appears likely that the client will be accepted into the facility, clearly explain to the director or intake worker that your agency would like to be involved in treatment plans until the client has made a smooth transition and no longer needs case management or that you would like to be an on-going service provider.

One final type of linkage that you may be called upon to make is between a client and the **police or jail**. If a client has a court case, you may be called upon to testify in court. If not, you should be present when the case comes to trial. There may be times when a client calls your agency to say that he or she has been picked up by the police and is in jail; if so, find out if he or she has been assigned to a jail social worker and establish immediate contact with that person. Clearly specify to the jail social worker that you are involved in the client's case and would like to be involved in any plans for his or her release.

Working with Collateral Service Providers

When working with collateral service providers, the first thing you must do is to **secure the client's consent** for any communication that passes between your agency and the collateral service provider. Legally, no information should be exchanged between you and a collateral service provider unless you have on file a valid consent form signed by the client. The consent form must outline the nature of the information to be shared and is generally valid for no more than one year, although this can vary, as long as the client agrees to it. After the consent form expires, no communication about the client should transpire between your agency and any other agency or organization until the client signs a new consent form.

The communication that takes place between you and another service provider working with your client will vary. One piece of information that is beneficial to **share** is the contents of the **treatment plans** for the client held by the two agencies. If both your agency and another organization are providing ongoing

services to a client, make plans to share treatment ideas with one another. It is also a good idea to have one another's treatment plans for the client on file.

As a general rule, you should establish **regular phone contact** with any collateral service provider who is doing ongoing work with one of your agency's clients. It is useful to make informal agreements with collateral service providers to the effect that they will phone you any time important information becomes available about one of your agency's clients.

There will be times when you see evidence that a collateral service provider is not meeting a client's special needs. As case manager for the client, your **advocacy** will be required in order to ensure that the client's needs are being met. There are several ways to advocate on behalf of a client to a collateral service provider. Establish a **"contact person"** within the collateral service agency, one who seems willing to help you in your efforts to secure proper services for the client.

After establishing at least a tentative relationship with a worker within the collateral agency, advocate for the client via **telephone or mail**, detailing to your contact the ways in which the collateral service provider could more accurately cater to the client's needs. It is often beneficial initially to establish contact about the client by phone and then to follow up this telephone conversation with a letter. In the letter, summarize the contents of your conversation, and list all decisions about the client which were reached during the telephone contact.

Staffings are another form of communication that are important when working with collateral service providers. Although you will be in regular contact with collateral service providers via telephone, arrange periodic, face-to-face case staffings. These meetings are used to ensure that services to the client are not being duplicated and that there are no gaps between the services being provided by both agencies.

When friendly advocacy on behalf of the client to the collateral service provider does not work, you may need to take a more active stance with the service provider in order to secure appropriate services. Pressure can come in the form of a letter to the collateral service agency's chief executive, governing body, or funding source(s), an influential mental health official, or your local congressional representative. Keep in mind that resources are scarce and caution is in order. Always involve your supervisor and obtain input regarding agency guidelines. Follow established procedures.

On-Site Advocacy

Some of the advocacy that you do for clients, instead of being done over the phone or by mail, will be done in-person. **On-site advocacy** entails accompanying a client to an appointment, helping to ensure that all runs smoothly so that the client obtains what he or she needs. As an assertive outreach worker you will perform on-site advocacy in a number of ways. Perhaps one of the most important ways to advocate for the client is to accompany him or her to **appointments regarding benefits.** When clients are making initial application or are being reconsidered for Social Security or Public Aid, you can directly assist them with the cumbersome procedures of these bureaucracies. In particular, you can use your knowledge of clients to convey information that will help ensure that they receive the benefits and services to which they are entitled.

Another way in which you will perform on-site advocacy is by accompanying clients to **medical and psychiatric appointments.** At these sessions, you will be able to provide input about the types of services and medications that you and the client feel will be most beneficial for him or her. Your presence at medical or psychiatric appointments is also important to the client in that you can offer moral support. Seeing a doctor or psychiatrist can be a frightening experience, so it is often helpful for you to be there for the client to offer reassurance.

When clients apply for **housing**, you will be called upon to be an on-site advocate. In such situations, you can help clients complete applications, serve as a reference for clients, and help clients determine whether or not they will be getting their money's worth if they decide to live there.

You will also perform on-site advocacy services for clients when they apply for **vocational programs** or for **jobs in the community.** Not only can the client use you as a reference, but you can help him or her fill out application forms. When clients apply for vocational programs, accompany them to the interviews in order to assist them in asking for services, providing information, and acting as a liaison to agencies.

When clients have **legal appointments**, you also will be called upon to act as an on-site advocate. Part of your job in this situation will be to make sure your client's rights and interests are protected. Accompanying clients to legal appointments is often necessary in order to provide them with moral support in stressful situations, to make sure that no one attempts to intimidate them, and to help them with details.

Finally, your services as an on-site advocate will be essential when clients are **interviewing and getting started with new social service providers** such as therapists or psychiatrists.

You can assist clients as they give new social service providers necessary background information and lend support to clients if they feel anxious or uncertain about how to proceed. By introducing yourself, you also become a necessary liaison for the new service provider in your client's network. Your presence and knowledge will be appreciated because of the information you have available and because of your relationship with the client.

Working with Inpatient Staff in Cases of Psychiatric Hospitalization

Although two important goals of assertive outreach are to help clients function well within the community and to avoid unnecessary psychiatric hospitalizations, there will be times when even the greatest efforts on the part of the assertive outreach team will not prevent a client from requiring hospitalization. When a client is hospitalized, there are several steps to take with inpatient staff which will facilitate your client's stay, as well as the assertive outreach team's subsequent relationship with him or her.

The first step to take when a client must be hospitalized is to **immediately make inpatient staff aware that you are following the client.** Call the inpatient social worker assigned to your client and inform him or her of your ongoing relationship with the client. Also make it clear that you wish to be involved in all treatment and discharge plans made for the client during the hospital stay. Provide necessary information, if you have the required signed releases, regarding current situations and plans.

Your work with inpatient staff will involve **negotiations regarding all treatment** proposed for the client, including medication and inpatient therapy. It is helpful to give the inpatient staff any details you have about the types of medication that the client is presently prescribed and to what he or she does or does not respond. If the client has been receiving IM (intramuscular) medication while in the hospital, you must make sure that the client is given a shot well before discharge so that it has ample time to take effect.

You also will need to **negotiate with inpatient staff regarding the client's discharge plans.** It is essential that you ask the inpatient staff not to proceed with discharge plans without consulting a team worker first. Let inpatient staff know that you would like to meet the client when he or she is ready for discharge and will continue to be the primary service provider after discharge. Included in your discharge negotiations with inpatient staff is advocacy in cases where you believe that the client is being discharged prematurely or is ready for discharge but no accompanying discharge plans have been made by the hospital staff.

Finally, if a client's case is a particularly complicated or difficult one, hospital staff may periodically hold **inpatient staffings** in order to discuss treatment ideas. If this occurs with one of your clients, clearly state to the inpatient social worker that you wish to be involved. These negotiations can be difficult because you want to maintain good relations with hospital staff. Ask for assistance from more experienced team staff and your supervisor.

Working with Families

Frequently, persons with mental illness who are homeless have inadequate "natural" supports, such as family and friends. Perhaps because of the nature of their illness, the naturally existing supports for these individuals are often weak, constricted, transitory, or unpredictable. The quality of the interactions between the client and other family members often may be so stressful that they have come to a mutual decision to limit or cease contact.

Clients have the right to keep the nature of their working relationship with your agency private. Some clients feel adamant about having no contact with family members and do not appreciate your attempts to involve family members in their treatment. It is imperative to respect clients' wishes if they insist that you not contact their family members. Although your own personal experience with your family may lead you to want to reunite clients with their family, remember that each individual has a choice in such matters. Always follow clients' leads regarding the question of whether or not family members should be involved in plans for treatment.

When clients and their families do desire involvement with each other, there are several things that you can do to facilitate this relationship. First of all, it will be important to **keep family members informed** about their relative's situation. Telephone the client's family in order to establish initial contact with them. Introduce yourself and explain the role that you will be playing in the client's life. Subsequently, notify the family any time important information becomes available about the client, as long as he or she approves of your conveying this information.

Second, take some time to **understand the family members' hopes for their relative.** Realize that the family has known their relative both before and after the onset of mental illness, and that their hopes may spring from memories of the client before he or she became ill. You can listen to the family members' hopes for the client and help them bring these hopes more in-line with those of the client. Families may need support to mourn the loss of their aspirations or come to terms with their relative's current situation.

Third, make a point to **incorporate input from family members into treatment.** Maintain regular contact with family members and listen to their ideas and resources for their relative. Work together with the client and family as a team in an effort to reach goals and a satisfying quality of life that reflects a middle ground for all involved parties.

It may be necessary to **help family members process disappointments** that they feel about their relative. Spend some time focusing solely on family members themselves, rather than on the client. Either by phone or in person, help them work through some of the ways that their expectations for their relative must change as a result of mental illness. The more family members come to terms with a client's illness, the better the interaction between client and family.

An essential component to working with families is **providing them with resources.** Refer family members to support groups for relatives and friends of persons with mental illness, groups that educate about mental illness and/or homelessness, and family advocacy groups. You also can inform families about community resources for their relatives with mental illness, such as psychosocial clubs, consumer-run services, or crisis services to contact in times of distress. An excellent contact is the local chapter of the National Alliance for the Mentally Ill. Many local hospitals and outpatient facilities offer family support groups for relatives of persons with mental illness. Keep an updated contact listing in your resource file.

UNIT 9

Making Sense of What You See and Hear: Processing Assertive Outreach Experiences

Coping with Some Common Client Issues

As you continue your job as an assertive outreach worker, you will realize that certain themes become recognizable in the content of your interaction with many different clients. This is not to say that every client will react in the same way to you. Rather, some issues that develop with clients are more common than others, and recognizing that these patterns exist will help you to be especially sensitive to your style of coping with these experiences.

Hostility is one common client issue that you will notice as you continue your job as an assertive outreach worker. The clients with whom you work may have many reasons to feel hostile. Often, clients feel **anger toward their life situations**; being homeless and having mental illness are two very difficult experiences. Be sensitive to the magnitude of pain involved in being an individual with mental illness who is homeless. If a client seems hostile, recognize that the source of his or her anger probably is tied in with his or her life situation. In order to build your empathic skills, imagine what it must be like to go through some of the experiences your clients have gone through. Only by putting yourself in your clients' shoes will you begin to understand the origins of their feelings.

Clients' hostility also may stem from a **need for personal space**, which, by your offers of help, you may be invading. It is not uncommon for clients to feel as if you are "always there," or that you never let them do things alone. Respect clients' expressions of hostility in these instances as healthy ones, illustrating their desires to be independent. Attempt to renegotiate your partnership so that it is more beneficial for both parties.

Finally, learn to **recognize danger in the face of excess client hostility.** You must become expert at distinguishing between "healthy" verbal outbursts and hostility that is verging on physical violence. If a situation seems potentially dangerous and a client is unable to be reasonable or rational, walk away from him or her for the time being. If threats of violence are made by the client, and you believe that he or she is actually planning to carry out the threats, call for help from your team or from the police. Your co-workers and supervisor will tell you the procedure to be followed.

Another common issue that emerges in repeated interactions with clients is **rejection.** Many individuals with mental illness who are homeless are wary of getting too close to others. It is essential to realize that rejections by others often have accompanied clients' mental illnesses, and that these rejections have subsequently instilled fear in clients about getting hurt in relationships with others. Therefore, you should slowly build trusting relationships with clients instead of forcing them to become close to you before they are ready.

Clients also may appear hostile because they express **resentment about your "intrusion" into their lives.** Some clients may initially (or permanently) reject your offers of help. However, this rejection may stem from feelings that you will be taking away their independence or that you will be interfering in their lives. These feelings are healthy ones and should not be misconstrued as resistance on the part of clients. If such situations occur, reassure clients of your intentions to help them improve the quality of their lives, not to make things worse.

Clients may feel burdened by your attempts to offer assistance. Some clients may have had numerous helpers in the past who ended up not being very helpful. They may assume you are just another in a long line of unhelpful helpers. As a related issue, clients may also feel a **need to test you** in order to determine whether or not your concern is real and to see if you will be there no matter how they behave. Some individuals may set up situations in which they believe you will turn against them. It is important to give clients the message that you are willing to stick with them regardless of how they act.

The third theme that you may notice running through many of your interactions with clients is that of **dependency.** A client's dependency upon the assertive outreach team can be both a positive and negative force. The **benefit of dependency** involves the fact that it is easier to help clients make steps toward improving the quality of their lives in the community if they rely on you, trust you, and believe that you will be helpful. This reliance may be illustrative of a strong investment on the part of clients in making positive changes in their lives.

However, you will also recognize some of the **perils of dependency** as you begin to build relationships with clients. For instance, client dependency is at cross-purposes with the ultimate goals of assertive outreach: namely, client self-empowerment and independence. Therefore, the more dependent clients are upon the assertive outreach team, the more their stability is in jeopardy if and when you begin to wean them from assertive outreach services.

Clients often will show **ambivalence about becoming independent versus remaining dependent upon you.** Ambivalence on the part of clients may become apparent in the mixed emotions indigenous to their relationship with you. They may fluctuate easily between "loving" you and "hating" you. In some ways, clients' ambivalence about being dependent on you is analogous to adolescents' reactions to their parents; there is a desire to separate from parental figures while, at the same time, needing their support.

Learn to **process your own feelings about clients' dependency.** Do you inadvertently foster dependence in clients out of some needs of your own? For instance, everyone knows that it feels good to be needed, but are your needs in this area so strong that you are actually encouraging clients to become more dependent on you? Become aware of any countertransference or co-dependency issues on your part, and process these with your supervisor or, if need be, with a counselor. Look for patterns in your interactions with clients. Do you react toward a particular client because he or she reminds you of someone else in your life? Do you have a tendency to try to "save" clients? If you notice these patterns, it will be important to work through them in order to avoid having them impede your working relationships with clients.

Finally, learn to **identify indications that clients need to test their ability to function independently.** For example, is a client beginning to do more and more on his or her own? Does she seem to be exhibiting more capable and responsible behavior? Is he deliberately missing appointments with you? Is he becoming angered when you help him accomplish something? Is she insisting on accomplishing tasks on her own? All of the above examples, although possibly indicative of problems with the client, are often indications that a client is ready to take greater steps toward independence. Pay attention to these signs and allow the client the opportunity to gain skills and improve his or her self-esteem.

Another common client issue is a **low tolerance for stress.** Many individuals with mental illness who are homeless are easily reactive or sensitive to stress. Certain stressful occurrences might precipitate psychosis or depression in clients if they feel incapable of dealing with the situation. Sometimes even small tasks, those of daily living, may create tension or seem overwhelming for clients. Therefore, it is important to help clients feel more secure about performing the ordinary tasks of daily life, and, in the meantime, try to remember clients' sensitivity to stress, so that you find a balance between expecting too little and expecting too much of them.

Two final themes that commonly will run through your interactions with clients are **limit setting** and **boundary issues.**

Limit setting issues generally arise around the subjects of money and dependency. As far as **money** is concerned, if your agency is a client's representative payee, it is essential that limits be set about a money disbursement schedule, so that the client learns the art of money management. The disbursement schedule should be adhered to except in cases of emergencies.

Another area in which limit setting is necessary is in regards to **dependency issues.** As mentioned above, it is essential to set limits as to how much you will do **for** clients. Because the ultimate assertive outreach goal for clients is helping them gain independence, do not allow clients to make you feel guilty about not doing enough for them. Continually remind clients that you are in a partnership with them, with the hope that they will gradually take on more and more of the responsibility.

Finally, it is in the client's best interest if you maintain a somewhat firm **boundary defining the nature of your relationship** with him or her. Do not allow a professional relationship to be transformed into a "best friends" or "parent-child" relationship, except perhaps in cases of consumer-run outreach services, where the nature of interaction between staff and clients may be built more on comradeship and shared past experiences. However, in general, work towards forming a close therapeutic relationship with clients, while keeping the case manager/client boundary firmly intact; this boundary will facilitate clients' transitions into independence.

Making Sense of What You See and Hear (Processing the Meaning of Clients' Homelessness and Mental Illness)

You will see much in your job as an assertive outreach worker that seems painful, unfair, and difficult to understand. In order to make sense of some of things you see and hear on your job, it will be important to process your experiences both internally and with other team members or your supervisor. Many seemingly basic questions about your clients may come to mind as you continue to work with them. Voice these questions, even if you feel they sound "silly," and talk about the answers with your colleagues.

A question that may cross your mind as you continue to work with persons with mental illness who are homeless is one that stems from the work ethic that is passed down to us through the generations, whereby hard work is generally equated with "goodness" or worth. You may wonder, **"why don't most of my clients work?"** The severity of mental illness often prevents clients from holding steady jobs. Also, the serious and long-term nature of the illness may prevent clients from accumulating enough job training or education to hold a job that pays more than can be received through disability benefits. Another factor

is that clients' sensitivity to stress may make them vulnerable to the demands placed on individuals through employment. Finally, lack of stable housing can contribute to a client's inability to find and keep a job.

You may also wonder, **"why are clients so isolated?"** Mental illness, especially schizophrenia, may cause clients to withdraw and, hence, affects clients' capacities for social relationships. Also, the symptoms of mental illness sometimes prevent individuals from being able to develop the types of social skills expected in most social relationships. Finally, individuals who do not have mental illness or who have never experienced homelessness often have a difficult time understanding the meaning of homelessness and mental illness and, thus, choose not to relate to individuals who have experienced these situations. This lack of understanding on the part of society in general further contributes to the isolation of persons with mental illness who are homeless.

At times, because of their illness or the medications used to combat it, clients may display body gestures that seem unusual or difficult to understand. It is possible that a client is displaying odd body movements because he or she is delusional and is responding to internal "voices" or commands. However, a client's body posture and gestures also could be a sign that he or she is experiencing negative side effects from psychotropic medication and needs to be examined by his or her psychiatrist. Familiarize yourself with some of the manifestations of the side effects from psychotropic medication, and respond to clients accordingly.

You also may find yourself concerned about the physical health of your clients and ask yourself, **"why are my clients often physically ill?"** If individuals with mental illness are homeless and living in substandard conditions, these persons will obviously be more susceptible to poor physical health. Also, many clients either may not be eligible for, or may not be receiving, Medicaid or Medicare and thus have not been able to obtain any medical attention. Finally, some clients' delusions, particularly if they are of a paranoid nature, may be preventing them from receiving ongoing medical care.

Finally, it would be odd not to wonder, **"what do the above conditions mean to clients,"** or, in other words, "how do clients come to terms with such difficult experiences?" It goes without saying that clients respond to their life situations in many different ways. Some express anger at their conditions. Others may appear to be oblivious to their experiences. Finally, many individuals with mental illness who are homeless turn their anger at life inward and manifest varying degrees of depression.

Processing What You Think and Feel

In order to continually grow in your role as an assertive outreach worker, it will help if you learn to identify your thoughts and feelings and learn from your responses. Your responses to these situations will take place on an emotional level, an intellectual level, and a behavioral level. In processing your thoughts and feelings, ask yourself a number of questions:

1. When you react **emotionally** to something that occurs with a client:
   a. what are your immediate feelings? (happiness, sadness, fear, sympathy, repulsion, anger)
   b. why are you feeling the way you are?
   c. what would need to occur in order for your emotional reaction to change?

2. If you are aware of experiencing a specific **behavioral or physical response:**
   a. what is that immediate behavioral reaction?
   b. is your response an obvious, negative one that the client notices?
   c. how can you make your behavioral responses more neutral and less judgmental?

3. When you react to a client on an **intellectual level:**
   a. what is the nature of and reasons behind your intellectual response?
   b. upon further reflection, do you think the situation could have been handled differently?

Processing your thoughts and feelings about clients and situations that occur with them can be done during **team meetings.** During these meetings, **present the facts** by conveying objectively details about a given situation with a client. Again on an objective level, get the team's input about how the situation might have been handled differently. You and your team members can generate a number of different possible responses to any given situation.

Team meetings are also ideal for **communicating your ideas.** Verbalize your thoughts about how certain situations with clients are being handled. If you have ideas about different ways to approach clients, convey these to team members in order to get feedback.

Finally, team meetings can also be used to **share feelings** about clients and your experiences with them. In a manner that is respectful to clients, express any positive or negative emotions regarding your interactions with them. Processing feelings about clients with colleagues is important in that this

type of exercise helps you to avoid carrying any negative emotions into the next day's transactions.

You do not have to wait until a scheduled team meeting to process information with your team. **Informal discussions with team members**, immediately following visits to clients, can be a valuable tool. Share your feelings about client experiences with available colleagues as soon as you come in from the field. It is helpful to be able to discuss important interactions you have had with clients while your feelings about them are still vivid. Also, these informal discussions can be used as "cool-down" times in an otherwise intense day. When a quick, informal discussion is not possible, make notes that will cue you later during the team meeting.

You also may want to informally process and get advice from more experienced team members. It is useful to find a "mentor" whose style of interaction with clients you particularly admire and from whom you feel you could learn. Talk frequently with this person, go on client visits with him or her, and feel free to pick up "pointers" about how to do assertive outreach <u>well</u>.

One of the most important places to process your thoughts and feelings about clients and your dealings with them is in **supervision**. There are many effective ways to use supervision. Sessions with your supervisor are good times to problem-solve about clients. Share excerpts with your supervisor from one-to-one interactions with clients whose problems are particularly difficult or challenging. You and your supervisor can talk through problematic situations or interactions together in order to formulate approaches to best handle difficult situations.

Supervisory sessions also should be a safe place in which to process feelings about clients. Share with your supervisor the emotional reactions brought out in you by interactions with clients. The private nature of supervision allows you to unload feelings that you might feel uncomfortable about bringing up in the presence of the entire team.

Although you may, at times, discuss personal feelings that are brought up by your experiences as an assertive outreach worker, supervision should **not** be a place in which to receive personal therapy. The purpose of supervision is to receive guidance regarding anything that might be connected to the job. Refrain from looking to your supervisor for advice about coping with personal problems, unless these problems might somehow interfere with your job performance.

Finally, because of the sometimes stressful nature of assertive outreach, you also may find it helpful to make use of **outside supports**. It is often useful to process feelings about your job with family or friends, making sure that you protect

clients by respecting all rules of **confidentiality**. While doing assertive outreach you also may want to take part in personal therapy or counseling. After some time on the job, you may find that you need extra help coping with issues. In addition, working through some of your own issues will carry over into your work with clients in a positive way. You will be able to free yourself of some of the personal problems that can interfere with your work and you will be able to help your clients reach a level of growth that you yourself strive for. Any steps that you take to learn more about yourself are likely to be beneficial for clients.

UNIT 10

The Larger Picture: Establishing Cultural Relevance, Increasing Your Knowledge Base, and Impacting Public Policy

Cultural Relevance

When you work with persons with mental illness who are homeless you will encounter individuals from many different cultural and ethnic backgrounds. Keep in mind that the factors shaping human beings' lives are numerous, with cultural backgrounds of individuals playing important roles.

Familiarize yourself with the differences between cultures, and strive to understand how these differences affect clients' behaviors. Instead of measuring each client against your "norm," look at each person individually, in the context of his or her cultural or ethnic community. For example, do your efforts to urge a client to increase his independence by living away from family conflict with his ethnic community's emphasis on interdependence? Does your explanation of mental illness as a medical condition resulting from faulty brain biochemistry contradict the teachings of indigenous healers from a client's ethnic culture such as "curanderos" or "espiritismos"? Find out from readings, from friends, and from clients and their families what values and behaviors are important to their cultures, and work with them accordingly.

Additional Training

As you continue in your position as an assertive outreach worker, additional training will be necessary to keep you informed of new developments in the field. One type of additional training will come in the form of agency **inservices**. Inservice trainings are meetings delivered by someone working within or outside of your agency, focusing on a particular area of the mental health or homelessness field. Plan to attend agency inservices. Also, if you come across a particular speaker or topic which you think might be of interest to others in the agency, arrange with your supervisor either to give your own inservice or to host a guest speaker.

Seminars are another good source of additional training. Often your agency will arrange for some or all of the assertive outreach team to attend seminars on relevant topics. If you become aware of a seminar about which others in the agency have not yet heard, advertise it by posting a sign on the agency bulletin board or sending around a notice. Attempt to gain permission for time off to attend seminars of particular interest

to you, and inquire about obtaining any extra agency funds to cover the cost of the seminar.

Receiving special **certification** in a specific area of the mental health field is a third way of acquiring additional training. Explore whether any of the experiences that you are undergoing at your agency can be counted toward social service certification, e.g., Certified Alcohol Counselor (C.A.C.) or Certified Substance Abuse Counselor (C.S.A.C.). If your experience as an assertive outreach worker is not relevant to any existing social service certifications, inquire about becoming certified, for instance, in alcohol counseling, through further academic preparation.

Finally, **additional education** will add to your expertise as an assertive outreach worker and may help you advance within your agency. Obtain information about your agency's policy toward covering financial and time commitments for continuing education for employees. Perhaps you could take an advanced class in a human service-related field or even begin part-time formal curriculum work leading to a higher degree.

Redefining Client Progress

Another concern to address as an assertive outreach worker is how to **define** or, in some cases, **redefine client progress.** One of the major goals of assertive outreach is to improve the quality of clients' lives in the community. However, the definition of "improved quality of life" is somewhat subjective, and the experience of improvement will differ from client to client. Nevertheless, there are common markers that can give you some objective "proof" that the quality of a client's life is improving.

Following are some client accomplishments which point to **improved quality of life:**

1. Obtaining and maintaining stable housing;
2. Obtaining at least temporary (ideally permanent) benefits;
3. Needing fewer psychiatric hospitalizations per year;
4. Improving social relationships;
5. Being able to successfully manage tasks of daily living; and
6. Generally "feeling better."

Another method for redefining client progress is to **set smaller, incremental goals** with clients. Neither you nor the client should expect overnight success through assertive outreach efforts. Instead, in partnership, set small goals with clients so that both of you achieve a sense of completion at the end of each incremental goal. Also frequently compare with clients

their present behavior and living situation with their past actions and life situation so that you both are aware of when "movement" is occurring. Celebrate each small success with a few words of pleasure, encouragement, satisfaction, and congratulations.

Making an Impact on Public Policy (adapted from Protection & Advocacy, Inc., March, 1990: Self-Advocacy Series)

Although direct service work with individuals is both beneficial and rewarding, there are also many advantages to addressing issues on a macro as well as a micro level. **Macro level work** generally consists of efforts to change over-arching policies that affect major groups of people. Because macro level work targets a common need among most individuals of a group and has as its goal the meeting of these individuals' needs through an encompassing policy change, it can be especially effective.

When viewing your work from a macro level, you will be indicating a commitment to making changes for all, rather than solely for individuals. Therefore, it may be necessary to work toward revision of laws dictating the methods of problem resolution for these individuals.

Furthermore, by impacting upon public policy, one is able to **provide greater preventive measures**, rather than applying "band-aid" solutions to problems already in existence. Finally, addressing macro issues can **create new rights or strengthen existing ones** for persons with mental illness who are homeless.

By looking at the problems of persons with mental illness who are homeless from a broader perspective, you can **work to increase funding** for an existing program or help to create new, needed programs. Working on a policy level can help to **raise the consciousness of the public and the legislature** around issues affecting persons with mental illness who are homeless.

Take time to learn **how bills are passed and policies created** in your state. Although some political activity is prohibited when working for a nonprofit agency, find out from your supervisor or the director of your agency what activities are permissible. When persons with mental illness who are homeless face the same set of problems over and over, and direct service with these individuals does not seem to be having a large enough impact, then the time is right for policy changes. Do write to your representatives at the local, state, and federal levels. Do keep informed about pending bills and changes. Attend community meetings and hearings and voice your opinion and experiences. Vote in elections and encourage those around you to vote.

Conclusion

Your job as an assertive outreach worker will be challenging and rewarding on many levels. Find support for yourself and your goals. Whatever academic and personal background you have brought to your job will be beneficial but will also be challenged in your own efforts to further professionalize yourself. Your work touches the lives of numerous persons and has enormous impact. Be proud of your efforts. Be humble and continue to learn. Please let us know if you would like additional information or if you have suggestions for improvement of this manual.

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ANNOTATED BIBLIOGRAPHY ON PERSONS WHO ARE HOMELESS AND HAVE SEVERE AND PERSISTENT MENTAL ILLNESS

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ABSTRACT: The author reviews the literature on general hospital psychiatry and on the homeless mentally ill. Ms. Bachrach discusses the links, barriers and paradoxes presented by the system and the population. Barriers include the inordinate amount of service needs, the geographic care system and a general failure to understand the illness. The author suggests a role for the general hospital unit.

Bachrach, L.L.; Santiago, J.M.; Berren, M.R.; Hannah, M.T. The homeless mentally ill in Tucson: Implications of early findings. Maryland Psychiatric Research Ctr., Catonsville, US. American Journal of Psychiatry. 145 (1) 112-113, January 1988.

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ABSTRACT: The author presents issues in defining and providing treatment to the homeless mentally ill. The author identified treatment barriers and outlines steps for more effective service delivery.

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ABSTRACT: Conclusions of a study group are outlined. The following points are agreed upon: 1) There is an unknown number of clusters of homeless individuals. Within these populations, substantial numbers exhibit clear psychopathology. 2) The population is increasing. 3) Statistical descriptions of the population should express both central tendencies and ranges. 4) A variety of diagnostic categories are reflected within the population including schizophrenia, affective disorders, personality disorders and substance use disorders. 5) Some individuals have histories of treatment while others do not. 6) Substantial numbers are impeded from access to a system of care for a variety of geographic, economic, psychological and regulatory barriers. The primary impediment to effective research is the lack of a precise definition of the target population.

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ABSTRACT: This article presents the lives of 38 persons following discharge from an inpatient hospital. The author suggests that the narrow interpretation of commitment criteria by service providers contributes to mental deterioration and homelessness. The author stresses the importance of reviewing the rights versus the needs of clients and the importance of civil commitment as a vehicle for treating some persons.

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ABSTRACT: This article presents the process of becoming involved in the criminal justice system. A naturalistic tracking methodology is used to study 132 persons following discharge from an inpatient facility. Forty-seven persons became homeless. Of those, 21 became involved with the criminal justice system. The author suggests that the tendency to decompensate in a non-structured environment along with the inability or unwillingness to follow through with community

aftercare contributed to the involvement of the criminal justice system. The author suggests that changes in the mental health system would prevent the criminalization of the population.

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ABSTRACT: This article traces the history of the population and discusses media coverage and reports in the literature in raising the consciousness of the public and the mental health field. Advocacy and deinstitutionalization are discussed.

Keilitz, I.; Hall, T. State statutes governing involuntary outpatient civil commitment. Mental and Physical Disability Law Reporter. 9(5) 378-397, September-October 1985.

ABSTRACT: This article presents a summary of state legislation regarding involuntary outpatient commitment. Some differences among the states are highlighted. Virtually every state has some provisi for compulsory treatment and care in the least restrictive environment. The authors do present the lack of unanimity in approaches.

Lamb, H. R. Deinstitutionalization and the homeless mentally ill. University of Southern California School of Medicine, Los Angeles. Hospital & Community Psychiatry. 35(9) 899-907, September 1984.

ABSTRACT: The author presents an argument stating that the way deinstitutionalization has been carried out has resulted in persons with a serious mental illness becoming homeless. Lack of planning regarding residential options and rehabilitation services have lead to unforeseen consequences. The author states that professionals in the mental health system should accept the dependency needs of the consumer.

Lamb, H.R. and Lamb, D. M. Factors contributing to homelessness among the chronically and severely mentally ill. Hospital and Community Psychiatry. 41(3): 301-305, March 1990.

ABSTRACT: This article reports on a study of 53 persons. An important factor contributing to homelessness was the disabling functional deficits of major mental illness. These deficits included disorganized thinking and actions, poor problem solving skills, inability to mobilize oneself, depressing and paranoia. Other contributing factors included a lack of a comprehensive mental health care system and substance abuse.

Levine, I. S.; Spaniol, L. The role of families of the severely mentally ill in the development of community support services. NIMH, Program for the Homeless Mentally Ill, Bethesda, Maryland. Psychosocial Rehabilitation Journal. 8(4) 83-94, April 1985.

ABSTRACT: This article addresses the increasing interest of families in developing program. Survey results involving the National Alliance for the Mentally Ill are reported. Suggestions for planning are included.

Levine, I. S. Homelessness: Its implications for mental health policy and practice. NIMH Office of State & Community Liaison, Program for the Homeless Mentally Ill, Washington, DC. Psychosocial Rehabilitation Journal. 8(1) 6-16, July 1984.

ABSTRACT: This article discusses the increased media attention, public and professional concern for the nation's homeless. An overview is presented as well as reasons for large number of persons with serious mental illness in the population.

Levine, I.S.; Lezak, A.D.; Goldman, H.H.; Community support systems for the homeless mentally ill. NIMH, Program for the Homeless Mentally Ill, Rockville, MD, US. New Directions for Mental Health Services. June No. 30, 27-42.

ABSTRACT: The authors describe problems and service requirement including ways of adapting the current Community Support Program approach. The authors suggest several changes and discuss structural barriers that must be overcome.

Lipton, F. R.; Sabatini, A.; Katz, S. E. Down and out in the city: The homeless mentally ill. New York University Medical Center, Department of Psychiatry. Hospital & Community Psychiatry. 34(9) 817-821, September, 1983.

ABSTRACT: This paper outlines the demographic characteristics, diagnoses, histories and disposition of persons who are homeless.

Lipton, F.R.; Nutt, S.; Sabatini, A. Housing the homeless mentally ill: A longitudinal study of a treatment approach. Human Resources Administration, Office of Psychiatry, New York, NY, US. Hospital and Community Psychiatry 39(1) 40-45, January 1988.

ABSTRACT: This article presents an experimental design follow up project. Persons were assigned to either an experimental residential treatment program or to standard postdischarge care. Persons were followed every four months. Those in the residential treatment program spent significantly more nights in adequate shelter, spent fewer nights in hospitals or undomiciled and were more satisfied with their living arrangements.

Marcos, L.R.; Cohen, N.L. Taking the suspected mentally ill off the streets to public general hospitals. New York City Health & Hospitals Corp., N.Y. New England Journal of Medicine 315(18) 1158-1161, October 1986.

ABSTRACT: The authors trace trends in involuntary evaluation and treatment of persons not capable of recognizing their need for psychiatric care. The persons are taken off the streets and taken to general hospitals. Public and private hospital options and public policy and discussed.

Martin, MA; Nayowith, S.A. Creating Community: Group work to develop social support networks with homeless mentally ill. Special Issue: Group work with the poor and oppressed. City Univ. of New York, Hunter College School of Social Work, US. Social Work with Groups: 11(4) 79-93, 1988.

ABSTRACT: This article presents social support networks developed through the use of social group work. Populations included men and women who were homeless and had a serious mental illness living in New York City. Clients utilized drop-in centers, shelters and single room occupancy hotels. The network groups developed included bingo, discussions of current events and cooking. The project effectively maintains persons in the community.

Milburn, N.G.; Watts, R.J. Methodological Issues in research on the homeless mentally ill. Howard Univ. Institute for Urban Affairs & Research, Housing & Community Development Studies Center. International Journal of Mental Health. 14(4) 42-60, Winter 1985-86.

ABSTRACT: The authors review methods used to study the population who is homeless. The studies vary in terms of content and rigor but generally are found to be sound in design. The author concludes that the conceptual framework underlying the studies is sometimes inadequate.

Morrissey, J.P.; Levine, I.S. Researchers discuss latest findings and examine needs of homeless mentally ill persons. University of North Carolina, Health Services Research Ctr. Chapel Hill, US. Hospital and Community Psychiatry. 38(8) 811-812, August 1987.

ABSTRACT: This article summarizes the proceedings of a National Institute of Mental Health meeting and discusses the findings of ten research projects concerning prevalence of mental illness in persons who are homeless.

Perr, I. N. The malignant neglect of the mentally ill street people. American Journal of Psychiatry. 142(7) 885-886, July 1985.

ABSTRACT: This article presents a case illustrating inadequate social policies regarding involuntary hospitalization. Estimates of diagnostic categories among the population who are homeless are given as well as causes of homelessness.

Putnam, J.F.; Cohen, N.L.; Sullivan, A.M. Innovative outreach services for the homeless mentally ill. Gouverneur Diagnostic & Treatment Ctr., Homeless Emergency Liaison Project, New York, New York. International Journal of Mental Health. 14(4) 112-124, Winter, 1985-86.

ABSTRACT: A mobile outreach crisis service is described. Several agencies collaborate to provide transportation for evaluation. Those persons judged to beat high risk but adaptive are monitored. The authors present a case for continuation of service.

Recommendations of APA's task force on the homeless mentally ill. Hospital & Community Psychiatry. 35(9) 908-909, September 1984.

ABSTRACT: The American Psychiatric Association recommends a comprehensive and integrated system of care. The system should designate responsibility, be accountable and have adequate resources. Specific recommendations are offered.

Searight, H; Searight, P.R. The homeless mentally ill: Overview, policy implications, and adult foster care as a neglected resource. Southern Illinois Univ., Edwardsville, US. Adult-Foster Care Journal. 2(4): 235-259, Winter 1988.

ABSTRACT: This article reviews the literature regarding persons with a mental illness who are single and who are homeless. The data suggests that 30% of the homeless have been hospitalized in a psychiatric inpatient facility. However, up to 80% of the population exhibit significant mental health impairment. The author's position is that a substantial number of the opulation are not receiving adequate community mental health services.

Stoner, M.R. Money management services for the homeless mentally Ill. University Southern California, School of Social Work, Los Angeles, US. Hospital and Community Psychiatry: 40 (7): 751-753, July 1989.

ABSTRACT: This article presents the outcome data analysis for 89 persons involved in a pilot money management project. Results indicate that incorporating money management into a flexible case management system can stabilize clients' lives.

Talbott, J.A. The imperative for psychiatric involvement in public policy. University of Maryland School of Medicine, Baltimore, US. New Directions for Mental Health Services. No. 37, 59-68, Spring, 1988.

ABSTRACT: The author asserts that increased attention to the formulation and implementation of public policy must be given greater priority. The author examines necessary steps to influence the environment including increased research support, improved housing and quality psychiatric treatment.

Talbott, J. A. Presidential Address: Our patients' future in a changing world: The imperative for psychiatric involvement in public policy. 138th Annual Meeting of the American Psychiatric Association (1985, Dallas, Texas). University of Maryland School of Medicine, Baltimore. American Journal of Psychiatry. 142(9) 1003-1008, September 1985.

ABSTRACT: The author presents an argument for the field of psychiatry to become involved with public policy. Issues of concern include: research support, assessment of treatment, payment concerns, deinstitutionalization, residential alternatives and the interface with the criminal justice system.